ALCOHOL RESEARCH UK

Project evaluation

Time of My Life: an Aquarius service supporting older people

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Executive Summary

Key findings

- The key components of TOML model are: a 1 to 1 service; group activities; community outreach and partnership work; a visiting service; a listening service; education and awareness; and a training programme.
- TOML model is grounded in an understanding of the different treatment and support needs of older people with alcohol problems.
- It offers a holistic approach which enables staff to respond to the person's needs beyond the alcohol intervention, e.g. social isolation, health and welfare support.
- TOML provides a flexible and responsive model with accessible staff and no rigid deadlines for service receipt.
- TOML project staff had varied professional experience. Some staff had spent many years in the alcohol field, while others were more recent recruits from a range of social and health care roles.
- The TOML model allows for the development of closer and more developed therapeutic relationships between users of the service and professionals and this relationship appears to be key to the success of TOML.
- The involvement of volunteers and peer supporters allow the TOML project to have a wider reach and offer a breadth of support it otherwise could not offer.
- Group activities appear to be the most challenging element of the TOML model in terms of maximising attendance and success. Those who attended valued them highly.
- TOML seeks to adopt a whole family approach and professionals report being able to offer more time to family members than would be possible in the parent service, Aquarius. Few family members were available for this evaluation.
- Staff learned quickly that working with an older client group required a change in attitudes and approach compared to 'practice as usual'. In addition, they required increased knowledge about health conditions and a commitment to partnership practice.
- TOML training improved preparedness for and attitudes towards working with older people with alcohol problems among both substance specialists and non-substance specialists although there was evidence of little change in the nature of practice with this service user group.
- In terms of economic evaluation, TOML will break-even providing people completing the programme maintain their target level of alcohol intake for 22 months (or 15 months if volunteer time is not included in the costs). However, these data are not available.
- Three features of the TOML service were highlighted as most sustainable without further dedicated project funding including the volunteer and peer supporter work, group work, partnership and training.
- Staff reflected that this group of older people had different needs and would not fit easily into a 'standard model' of service, necessitating the retention of a specialist older people alcohol service.

Background

The Time of My Life (TOML) project is an alcohol service supporting people aged 50 years

and older who want support with alcohol-related problems. Based in Birmingham, the TOML project is one of a number of services delivered by Midlands-based alcohol, drugs and gambling charity, Aquarius. In 2015, Aquarius and Alcohol Research UK co-funded a realist evaluation of the TOML project. This report presents the findings from that evaluation conducted, primarily, in year 2 of the project. In particular, it presents the perspectives of a range of people who deliver or use the TOML project and should be read in conjunction with Aquarius' TOML monitoring data.

Alcohol and older people

Concern has been growing about the alcohol consumption of the UK's older population. The 2014 Adult Psychiatric Morbidity Survey found that "harmful or mildly dependent" drinking, while reducing for younger adults (16-24 year olds), was increasing among people aged 55-64 (Drummond et al. 2016). In addition, national data have shown for some years that, while older age groups are more likely to be teetotallers, they are also more likely to have consumed alcohol daily compared with their younger counterparts (Department of Health 2016a; Office for National Statistics 2016).

Awareness of these changes in alcohol-related harm among older people has led to calls for a change in the national alcohol unit guidelines for older people. These have been ignored by national policy to date. However, new national guidance issued by the Chief Medical Officer for the UK in 2015 recommends weekly unit intake should be no more than 14 for both men and women. Further, it includes older people in a short list of groups who may be affected more by alcohol consumption and who therefore "should be more careful" about their drinking (Department of Health 2016b: 4).

There are few specialist alcohol services for older people in the UK (Wadd et al. 2011). Many services will support older drinkers but this is via mainstream services rather than specialist service models for older people. In the 2013 *Drug and Alcohol Needs Assessment* report from Public Health Birmingham (Kilgallon 2013) there were 21 agencies identified as offering some level of support for people with substance problems. There is, however, only one known specialist older people's alcohol service. This is the Time of My Life (TOML) project run by Aquarius.

Methods

This evaluation used an adapted version of a realist evaluation framework (Pawson and Tilley, 2004). Realist evaluation sets out to determine what works, for whom, how and in what context. Realist evaluation has three core concepts to support this process: Context, Mechanism, Outcome. Drawn together they help develop a model that describes what works and in what conditions.

A range of perspectives were sought for this evaluation and a range of the most appropriate data collection and analysis methods were chosen as a result. The final sample population and data collection methods are set out in Table 1 below:

Table 1: Summary table of sample population and data collection approaches for TOML evaluation

Sample population	Number	Data collection
• Direct users of TOML services, that is, older people who had used or were currently using one or more of the services provided by TOML	22	Semi-structured Individual face to face or telephone interviews
• Service users of TOML group activities	15	Focus groups
• Family members who were receiving some form of support from TOML	5	Individual (semi-structured) or group interview
• Volunteers and peer supporters who were helping to deliver one or more TOML services	7	Focus Group
• Paid TOML staff, including managers, practitioners and support workers	17	Semi-structured Individual face to face or telephone interviews
• Professionals/practitioners from other organisations who had received training from TOML	382	Paper based and online survey tool

In addition, the evaluation involved a 'break-even' economic analysis.

All interview and focus group data were audio recorded and then fully transcribed using a professional transcription service. The qualitative software computer-based package, NVivo v10, was used to aid the development of codes and themes. These themes were then mapped onto the different components of the programme, e.g. group work, family work. Quantitative data from survey of practitioners receiving the TOML training were analysed using descriptive and bivariate statistics (i.e. Correlations, Comparative t-tests) according to the research objectives. Inferential statistics that included Pearson Product Moment Correlations, were computed to determine the extent to which professionals' characteristics, their perceptions of their own preparedness and their knowledge and attitudes towards working with problematic alcohol users were associated with their current professional practice as defined through their reports of working with older alcohol users and with specialist services. . Comparative t-tests were used to explore the extent of change in attitudes, skills and practices of professionals before (T1), immediately following (T2) and three months after (T3) the training programme. The analyses were conducted using IBM SPSS Statistics 22 (Statistical Package for Social Sciences, version 22).

Full ethical consent was obtained from Manchester Metropolitan University's ethics committee.

Findings

The findings below are the key messages drawn from each chapter of the full final report:

How the TOML model differs from practice as usual

- The TOML model is grounded in an understanding of the different treatment and

support needs of older people with alcohol problems.

- It offers a holistic approach which enables staff to respond to the person's needs beyond the alcohol intervention, e.g. social isolation, health and welfare support, but which are often related to it.
- Service users have mixed views about the benefits of an over 50s service specifically – some are in favour and others feel it should be available to all ages.
- TOML provides a flexible and responsive model with accessible staff and no rigid deadlines for service receipt.
- There are a range of services available in a number of different locations across the City, which allow for a 'mix and match' approach to be offered to service users.
- Partnership working has been built in to the model from the start to ensure people's wider needs are met.

Volunteer and peer supporters' service

- Volunteers and peer supporters allow the TOML project to have a wider reach and offer a breadth of support it otherwise could not offer.
- Volunteers and peer supporters offered life experience to service users in a way that many professionals could not or would not feel able to disclose.
- Volunteers and peer supporters were highly valued by their TOML colleagues and this was conveyed to them and felt by them.
- Volunteers and peer supporters were able to develop their own skills and confidence while providing a support for both service users and TOML colleagues.

Individual work

- The TOML model allows for the development of closer and more developed therapeutic relationships between users of the service and professionals.
- TOML service users report feeling supported not patronised and given confidence and encouragement to take control of their drinking.
- TOML service users also report a range of benefits in reducing or stopping their drinking including improved physical and mental health, improved relationships with family and friends, and greater preparation for work.
- Drink diaries were among the tools identified as helping people to change their drinking behaviour.
- TOML service users felt strongly that ongoing support would be available to them from TOML or Aquarius should they need it.

Group activities

- Group activities appear to be the most challenging element of the TOML model in terms of maximising attendance and success.
- The successful groups appear highly valued by those who attend due to the peer support, socialisation, skills development and confidence building some groups can offer. They also provided an alternative or distraction from drinking.
- Staff report that some groups have a focus on alcohol whereas others focus on social isolation and have little, if any, alcohol-related content.
- Service users held a range of views about the groups being age specific. Those who were unsure had experienced the loss of peers when adult service provision was lost to

Aquarius and service users had to go elsewhere.
- Service users reported the management and facilitation approach of groups was good, balancing encouragement and direction with a relaxed approach.
- Difficulties accessing some groups were highlighted by both service users and volunteer and peer supporters. Transport provision was identified as one way to help people attend as was increased promotion of the group activities by TOML staff to individual clients.

Family work

- TOML seeks to adopt a whole family approach and professionals report being able to offer more time to family members than would be possible in the parent service, Aquarius.
- Family members were all accessed through their relative receiving TOML support, with some family members subsequently choosing to take up the opportunity of 1-1 support.
- Support for family members varied and could be providing information and education on alcohol, or it could be emotional support.
- Family groups were not running during this evaluation which could suggest the challenges of group work identified previously extend to family member groups.

Reflections on service delivery

- Staff learned quickly that working with an older client group required a change in attitudes and approach although there remained some evidence of stereotypical assumptions.
- Staff spoke strongly about the increased level of skills they needed to work well with this older client group, particularly in relation to patience and listening skills.
- Staff were working with a range of health issues and had to adapt their practice accordingly, often working with hospitals and other health professionals.
- Models of practice for mainstream services were not appropriate for this client group who often a) had complex needs as a result of age-related health conditions and b) had lived far longer with problematic alcohol use.
- The location of service delivery held great importance in terms of ensuring service access. This applied to the availability of home visits but also the knowledge of appropriate community venues for group work.
- Key challenges include time pressures and having such a small team for such a big City. Staff were sometimes frustrated at the limitations imposed by a lack of staff resource.
- Working with the new central Birmingham provider, CRI (now CGL), presented a number of operational challenges for both service users and staff.
- Few service users identified areas for improvement but among those who did suggestions included longer hours and greater flexibility in appointment times, the need for more staff, and concerns about changes in staff.
- The volunteer and peer support staff had been more firmly embedded in the TOML service during the course of the evaluation period. Their range of tasks and responsibilities had also grown but there was a need to improve referrals to the visiting service and to increase service availability.
- Volunteers and peer supporters felt greater promotion of TOML project was needed to ensure they were reaching socially isolated people.

Training evaluation

- Prior training in working with people with alcohol problems was low for non-substance specialists and previous training in working with older people with alcohol problems was low for both groups.
- Based on responses to a study specific questionnaire containing scales for preparedness for, knowledge of, and attitidues towards working with older people with alcohol problems the training the evaluation found:
  - Substance specialists scored more positively than non-substance specialists at T1 in terms of preparedness to work with adults and with older people who had alcohol problems. The training increased the scores of both groups on this measure, although the differential between the groups remained.
  - A similar pattern was seen in relation to knowledge, sense of legitimacy and willingness to engage with alcohol issues. The scores of substance specialists were higher than those for non-substance specialists throughout but again, for both groups, scores on all domains were higher at T2. Among non-substance specialists greater increases in attitude scores were seen for knowledge and legitimacy than was the case for engagement (willingness or comfort with working with alcohol users). Scores for role support indicated that non-substance specialists felt more confident about being able to source support after the training.
  - The increase in scores for non-specialists on all the above measures were sustained between T2 and T3.
- Current practice in working with older people with alcohol problems was found to be low on average across both participant groups and T3 data showed little change in this for non-substance specialists (data not available for substance specialists)
- Currrent practice was associated with prior training, preparedness and all four domains of the attitude scaleand whether or not they were social work students. Higher levels of current practice were associated with greater levels of prior training, preparedness and higher scores on all four domains of the attitude scale. Lower levels of practice with older alcohol users were also observed for participants who are social work students as opposed to other participants. However, causal links cannot be inferred.

Economic evaluation

- A break-even analysis was conducted. This is a form of economic evaluation which assesses how much change TOML would need to make, in monetary terms, in order for the costs of the project to be covered.
- The total costs of TOML project are approximately £495,141.00 per year (including volunteers' time), or £340,040 (excluding volunteers' time).
- The annual social savings are estimated to be £272,157.00.
- TOML will break-even providing people completing the programme maintain their target level of alcohol intake for 22 months (or 15 months if volunteer time is not included in the costs). However, these data are not available.
- There is a need for improved data collection in order to conduct a more definitive economic evaluation, for example, a benefit/cost or Social Return on Investment analysis.

Sustainability

- Staff were fully aware of the requirement for further funding to retain the TOML project and its model in the current form.
- Three features of the TOML service were highlighted as most sustainable including the volunteer and peer supporter work, group work, partnership and training. The latter was seen more as a legacy of the project rather than a service that could continue without TOML.
- Staff reflected that this group of older people had different needs and would not fit easily into a 'standard model' of service, necessitating the retention of a specialist older people alcohol service.
- Ideas for future service development primarily included the further development of existing services in the TOML model, in particular the TOML training, groups, volunteer and peer support programme and increased working with family members and carers.
- Increasing the number of staff was seen as key to developing the service.

Recommendations[1]

1. Disseminate the model, the learning from it, and its development as an alternative model to engaging and working with older people with alcohol problems and co-existing needs.
2. Continue to commit resources to recruiting, training and retaining TOML volunteers and peer supporters in order to sustain their contribution to the TOML model.
3. Review the continuation of groups at which there are no or few TOML clients and whose needs are not social isolation *in addition* to alcohol-related support.
4. Consider options for shared transport arrangements or other travel support to maximise group attendance.
5. Consider service provision out of 'office hours' to maximise support offered to family members who work.
6. Review promotion of, and referrals to, the visiting service to ensure that service use is maximised.
7. Formalise feedback routes to, and from, the volunteers and peer supporters about their contribution and development needs.
8. The training was received well and should be continued, however consideration could be given to booster sessions or organisational support to ensure change in practice.
9. Review monitoring and recording of client data to ensure reliable analysis of unit consumption pre and post TOML service for example. Build in a follow up period of up to 6-12 months post discharge to support effectiveness analysis.
10. Future research should include an outcome measure that explores health and well being.
11. Further research is needed with a larger group of family members to determine their views on, and experiences of, the TOML service.
12. Conduct a follow up survey to determine the progress of former services users after one, two and three years.
13. Review data collection to ensure the possibility of a cost-effectiveness analysis in future.

[1] A full list of recommendations can be found in the full final report available at alcoholresearchuk.org

Introduction

This report presents the findings of a realist evaluation of the Time of My Life project run by alcohol, drugs and gambling charity, Aquarius. The Time of My Life (TOML) project is an alcohol service dedicated to working with older people (50 years of age or more) in the City of Birmingham, West Midlands.

The report has been structured to focus primarily on the various components of the TOML programme. It begins with a brief summary of literature relevant to alcohol consumption among older people (chapter 1). Chapter 2 provides an overview of the TOML project, its services, model and staffing, before providing a summative overview of the methodology used in this evaluation (chapter 3).

Chapter 4 begins to present the findings of the evaluation. The chapter sets out professionals' and service users' perspectives on what makes the TOML different from mainstream alcohol service provision. Chapters 5-8 present findings in relation to four key elements of the TOML service, the volunteer and peer support services, individual work, group work and family work.

Chapter 9 presents professionals' reflections on their learning from the TOML project to date which ties in with one of the key aims of the evaluation, that is, to identify the lessons learned from the first year of the TOML project. Chapters 10 and 11 focus, respectively, on an evaluation of the TOML external and internal training programme and an economic evaluation of TOML. Chapter 12 identifies areas for sustainability from the perspectives of service users and professionals.

Chapter 13 is the penultimate chapter and draws together the key findings in the framework of a realist evaluation before the final chapter which summarises the evaluation's recommendations.

Chapter 1: Background

The Time of My Life (TOML) project is an alcohol service supporting people aged 50 years and older who want support with their drinking and alcohol-related problems. Based in Kingstanding in North Birmingham, the TOML project is one of a suite of specialist services developed and delivered by Midlands-based alcohol, drugs and gambling charity, Aquarius. The Time of My Life project is the only Aquarius project that has a specific focus on older people and one of few specialist services in the UK. TOML was funded for three years from 2014-2017 by the Big Lottery Fund.

The launch of the TOML project was set within a wider context of rapidly changing services and retendering for alcohol and other drug services in Birmingham. This retendering resulted in the loss of Aquarius' core adults' service to an organisation known as CRI[2] with staff being transferred to the new organisation or made redundant.

In 2015, Aquarius and Alcohol Research UK co-funded a realist evaluation of the TOML project. This report presents the findings from that evaluation conducted, primarily, in year 2 of the project. In particular, it presents the perspectives of a range of people who deliver or use the project and should be read in conjunction with Aquarius' monitoring data for the TOML project.

1.1 Alcohol and older people: a national picture

1.1.1 Ageing population

The Office for National Statistics (ONS 2015) states the number of people aged 60 and over currently[3] comprises 20.1% of the UK population. By 2039 it predicts this will have increased to 31.8%. Its data show that among people aged 75 and over, there is a projected increase of 89.3%, to 9.9 million, in the same time period. It continues:

> "The number of people aged 85 and over is projected to more than double, to reach 3.6 million by mid-2039 and the number of centenarians is projected to rise nearly 6 fold, from 14,000 at mid-2014 to 83,000 at mid-2039. This increase in the numbers of older people means that by mid-2039 more than 1 in 12 of the population is projected to be aged 80 or over." (ONS 2015, online)

With this ageing population comes a social and political realisation that existing health and social care systems and structures must adapt and do so quickly to ensure the needs of this older population will be met.

In 2015, the National Institute for Health and Care Excellence (NICE) published *Older people*

[2] CRI has recently changed its name to CGL, (Change, Grow, Live) but CRI will be retained in this report as the name of the organisation at the start of the research and one with which participants are familiar.

[3] Based on 2014 data.

with social care needs and multiple long-term conditions. The document offers national guidance on "person-centred social care and support for older people with social care needs and multiple long-term conditions" (p.19). Its states:

> ... a person with social care needs is defined as someone needing personal care and other practical assistance because of their age, illness, disability, **dependence on alcohol or drugs**, or any other similar circumstances. This is based on the definition of social care in section 65 of the Health and Social Care Act 2012. (NICE 2015: 14) (*our emphasis*)

To date, evidence suggests that non-substance specialist health and social care services have failed to adequately engage, identify and support people with alcohol or other drug problems (Galvani et al. 2011; van Boekel et al. 2013). It also suggests that older people's use of alcohol in particular has been overlooked (Dance and Allnock, 2013). Given the ageing demographic this is not tenable.

1.1.2 Alcohol consumption among older people

Concern has been growing about the alcohol consumption of the UK's older population. The 2014 Adult Psychiatric Morbidity Survey found that "harmful or mildly dependent" drinking, while reducing for youngest adults (16-24 year olds), was increasing among people aged 55-64 (Drummond et al. 2016). In addition, national data have shown for some years that, while older age groups are more likely to be teetotallers, they are also more likely to have consumed alcohol daily compared with their younger counterparts (Office for National Statistics (ONS) 2016). Older men are also more likely to consume far more alcohol than older women (ONS 2016).

Holley-Moore and Beach (2016) report a range of reasons cited by older people for drinking including being sociable, liking the taste or feelings from it, relaxation, pain relief, an aid to sleep, feelings of loneliness, boredom and depression. They also highlight how "higher risk" drinkers are more likely to drink alone and drink when feeling down, depressed, lonely or bored compared to lower risk drinkers. However, the highest percentage of higher risk drinkers reported drinking to take their mind off their problems (78%) or because they liked the taste or the way it made them feel (75%).

Alcohol-related harm, including those fully and partly attributable to alcohol, for example, alcoholic liver disease or falls respectively, is also increasing among this age group. Hospital admission data show that of all age groups, older people have the fastest rate of increase of alcohol-related hospital admissions compared to any other age groups (Wadd and Papadopoulos 2014). In an age sensitive reanalysis of existing Government data on alcohol-related deaths, hospital admissions and drinking behaviour studies, Wadd and Papadopoulos (2014, online) highlighted both the concerns about alcohol-related harm among this age group and also how, by looking at alcohol consumption only, this is a group of people who could easily be dismissed as drinking far less than other groups:

> Data presented here suggest that (1) older adults are more likely to be admitted to hospital for an alcohol-related condition than younger adults; (2) alcohol-related age-adjusted hospital admission rates have increased

> across the age-range but the most significant increases have occurred amongst older adults; (3) alcohol-related age-adjusted death rates are highest in the 55–74 year age group; (4) older adults drink less and are less likely to exceed the recommended limits than younger adults; and (5) alcohol consumption and the prevalence of excessive drinking has remained relatively stable amongst older adults in the last two decades.

Awareness of these changes in alcohol-related harm to older people has led to calls for alcohol unit guidelines for older people to be developed which recognise the physical changes in older age and the resultant inability of an older body to process the alcohol as effectively as it did when younger. These have been ignored by national policy to date but the Royal College of Psychiatrists (RCP)s has proposed its own recommendations (RCP 2011). It states that older people's intake should be no more than 11 units weekly compared with the 14 weekly units set for women and the 21 units weekly limit set for men. The RCP advises no more than 1.5 units daily for older people compared to an upper limit of 3 units for women and 4 units for men (RCP 2011).

However, new national guidance issued by the Chief Medical Officer for the UK in 2015 has not set different recommendations for older people. Instead, it recommends no daily unit guidance and states that the recommended weekly units should be no more than 14 for both men and women. Further, it states:

> Some groups of people are likely to be affected more by alcohol and should be more careful of their level of drinking on any one occasion:
>
> - young adults
> - older people
> - those with low body weight
> - those with other health problems
> - those on medicines or other drugs
>
> As well as the risk of accident and injury, drinking alcohol regularly is linked to long term risks such as heart disease, cancer, liver disease, and epilepsy. (Department of Health 2016b: 4)

This shift in policy to reducing units for everyone and acknowledging the increased care needed by some groups of people may not go far enough for some advocates but at least it begins to reflect a dialogue which recognises that older people are a group of people whose alcohol intake may need specialist attention.

1.1.3 Alcohol treatment for older people

There are few specialist alcohol services for older people in the UK (Wadd et al. 2011). Many services will support older drinkers but this is via mainstream services rather than specialist service models for older people.

A report on treatment data published by Public Health England (PHE) showed the most recent figures for people receiving treatment for alcohol or other drug problems in England (Knight 2015). The report concluded that not only is the age profile of people in treatment rising but they are bringing with them poorer health status, a "range of vulnerabilities

associated with long-term drug use" and the requirement for "a wide range of support, including social care" (p. 5). Further, the report noted that people with alcohol problems only – as opposed to drug only or poly drug/alcohol use - "had an older age profile than opiate users" and that the number of people aged 50 and over accessing services increased by 44% since 2009-2010. The report goes on to state "Many of these people will have been drinking at high-risk levels for some time and are likely to be experiencing health harm such as liver disease and hypertension." (p.5).

PHE's change in policy on data collection also reflects an awareness of older substance users and their presentation to treatment. The age limit for treatment data monitoring has been extended to 100 years old. PHE highlight that alcohol, in particular, is of concern among this older group and that people who are presenting to treatment with only problematic alcohol use (rather than polysubstance use) constitute 68% of clients in treatment who are 40 years and over, and 11% aged 60 years and over (p.17). The report (PHE 2015) also sets out the number of deaths of people who were receiving alcohol services. In 2014-15 they recorded 792 deaths among people in alcohol treatment. The median age was 49, just one year below the TOML age range.

For older people who do engage with treatment, evidence shows that their outcomes are as good, if not better, than younger adult populations (Wadd and Galvani, 2014).

1.2 Alcohol and older people: a regional profile

According to data collected in the 2011 Census, more than one million people live in Birmingham (n=1,073,045.00) (Office for National Statistics 2012). Of this population, 17.2% of Birmingham residents are aged 60 and over. An additional 16.4 % fall into the 45-59 age range. These figures fall slightly below the England average of 22.6% of people 60 and over with an additional 19.4% in the 45-59 category. Ethnically, just over half the population of Birmingham are White British residents (53%), with the next highest number of residents being Asian Pakistani (13.5%). Of those who identified as having a religious belief, 46.1% identified as Christian, with the next highest group being Muslim (21.8%) (ONS 2012).

Alcohol consumption data for the West Midlands region show it has the lowest percentage of people claiming to have drunk more than 14 units on any one day in the previous week (ONS 2016). It is also the region with the second highest reported number of teetotallers (ONS 2016). This is likely to be attributable to its ethnically diverse population and the religious prohibition of alcohol in many of the religions followed by these populations.

However, in spite of this evidence, the Local Alcohol Profile for England (LAPE) data show a different picture. LAPE data shows Birmingham fared worse than the national average for England in all measures relating to alcohol-related hospital admissions and alcohol-related mortality (PHE 2016a). Indeed, there were very few alcohol-related measures which were better than, and/or not significantly different to, the average profiles for England, and these were primarily related to some mortality and morbidity measures for young people and women (PHE 2016a).

According to the National Drug Treatment Monitoring Service (NDTMS), the latest data for successful completion of treatment for alcohol in Birmingham was slightly above the

England average at 39.6% (for England this was 38.4%), however Birmingham also had a higher percentage of people waiting more than three weeks for 'alcohol treatment' than the England average (6% and 4.6% respectively) (PHE 2016b). There are no available regional or City-based data available on treatment completions for older people specifically in services.

Importantly, Birmingham's Drugs and Alcohol Needs Assessment (2013/2014) (Kilgallon 2013: 8) made 14 recommendations, including recommendations 8-12 which are most relevant to an alcohol project for older people:

> 8) Outreach programmes should be co-ordinated between service providers to maximise contact with hard-to-reach communities
> 9) Care co-ordination could be improved by having a single organisation managing client pathways into treatment and recovery.
> 10) A classification system should be introduced to measure the complex needs of the client and offer personal choice of service. This segmentation process would also identify specific groups (e.g. dependent drinkers, injectors, etc.). …
> 11) Treatment services should focus on clients with the most complex needs.
> 12) Specialist services should engage with mainstream treatment providers to encourage engagements and successful completions in treatment.

As this evaluation shows, these recommendations are fully or partially addressed in the development of the TOML model.

1.3 Current service provision

In the 2013 *Drug and Alcohol Needs Assessment* report from Public Health Birmingham (Kilgallon 2013) there were 21 agencies identified as offering some level of support for people with substance problems including those specialising in work with offenders, homeless people, women involved in prostitution as well as wider community-based substance use services.

There is, however, only one known specialist older people's alcohol service. This is the Time of My Life (TOML) project run by Aquarius.

Chapter 2: The Time of My Life model

"It's a model with lots of different layers to it…" (TOML staff member 1)

The Time of My Life service (TOML) is one of a number of specialist services run as part of Aquarius, a Midlands-based charity which supports people with problematic alcohol, drug and gambling behaviours. Aquarius operates in and around the City of Birmingham with projects spanning the East and West Midlands.

2.1 TOML pilot project

The TOML service started in April 2014 and, at the time of writing, was commissioned to run for three years until March 2017. Work to underpin the project's development began in 2010 with an academic and clinical research scoping exercise to determine the extent to which there was a need for a specialist alcohol and older people project (Templeton, 2011). The scoping exercise explored the issues for older people accessing alcohol services, the needs of, and challenges for, health and social care services locally working with this population, as well as the facts and figures associated with older people's drinking. Thus it comprised meetings and focus groups with professionals from health and social care, consultation with older Aquarius service users, networking with other older people specific agencies, assertive outreach to deliver a service to a small number of older people and wider collation of knowledge around alcohol and older people.

The research led on to a pilot for the Time of My Life project, led by an experienced Aquarius manager with a small number of staff. The project ran for 15 months from start of January 2013 to March 2014 and was evaluated independently (Ward, 2014). The evaluation highlighted 14 key lessons about working with this older service user group which was taken forward to a bid for funding from the Big Lottery Fund for a three year Time of My Life Project.

2.2 TOML service outcomes

As a result of the pilot work, the following outcomes were set for a three year project proposal for the Time of My Life project:

- To reduce the isolation of older people at risk of/currently experiencing problems related to alcohol consumption.
- To increase the resilience of older people to support transitions in their lives.
- To reduce problematic alcohol use.
- To improve the health, quality of life, relationships and social networks among older people.
- To support older people to particpate in volunteer work to increase their self-esteem, confidence and social networks and as an alternative to drinking at transition points in their lives.
- To equip Birmingham based health and social care professionals, present and future,

with training to support better practice in screening and referring older people using alcohol to specialist services.

- To reduce discrimination and apathy among health and social care professionals, ensuring their policies and procedures reflect this.
- To embed older person assessment tools and more inclusive policies and procedures in substance use organisations nationally, resulting in better support for older people and improved outcomes.

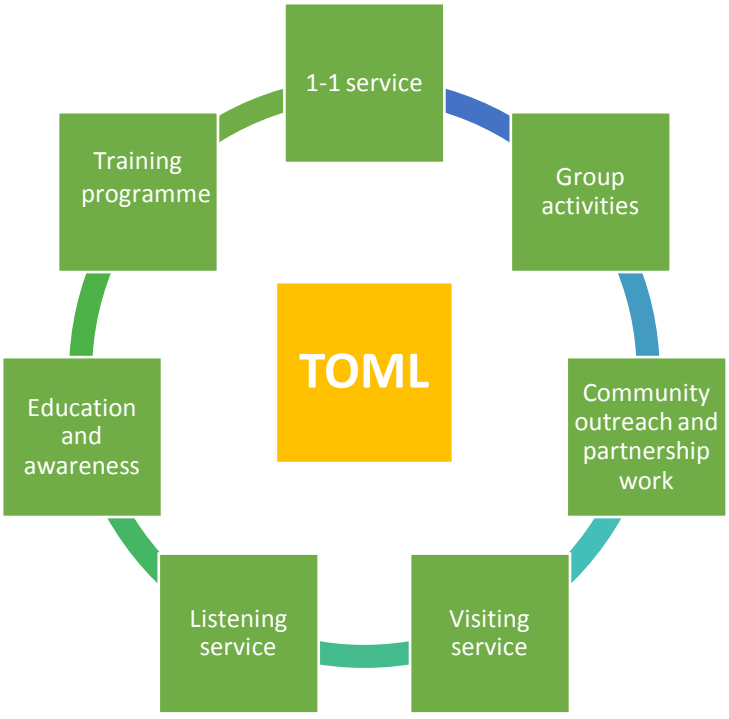
(Aquarius, TOML application form, 2013)

These were broken down further into key indicators with target number or 'indicator levels' and timescales attached to each one. While the role of this evaluation is not to duplicate the annual monitoring data Aquarius and TOML provides to its funder, nor to conduct any longitudinal survey of impact, it is worth noting the intended outcomes by way of backgroud to this realist approach to evaluation and its findings.

2.3 TOML model and approach

To deliver these outcomes the TOML model was designed with the following core components:

Figure 2.1: The TOML model



These components comprise a service that is delivered in community settings, for example, activity groups are run in libraries or community halls; individual and family work (including the visiting service) is conducted in people's homes – particularly where people have difficulties leaving the house - and/or in the TOML offices based in the Kingstanding and

Edgbaston areas of Birmingham. In addition, outreach work is done within hospitals in Birmingham and there are a number of fora at which TOML has representation including the local safeguarding boards. The education and awareness events including training and one-off events are held in a range of venues in the community and with a range of community partner agencies.

Interventions

The interventions delivered vary with the different strands of the service.

- Interventions for the 1-1 work are based on a number of methods including Motivational Interviewing techniques, and Cognitive Behavioural interventions.
- Group work is more activity focussed and designed to address social isolation in addition to alcohol consumption; for example, art, IT, knitting, allotment groups..
- Family work is varied but most family work is conducted in conjunction with the person with the alcohol problem rather than supporting family members in their own right. Family work comprises the education of family members around alcohol and its impact on their relative and support for the efforts of family members to support their relative. On occasion it entails staff taking control of crisis situations at home where family members are not handling them well.
- The training comprises a flexible training programme lasting approximately three hours according to prior knowledge and need. It is held in a range of locations around the City.
- Education and awareness initiatives, and community outreach, vary from conferences and events to advice to, and consultation with, collegues from other professions, e.g. hospital staff.

The Listening and Visiting Services were introduced in year 2 of the project

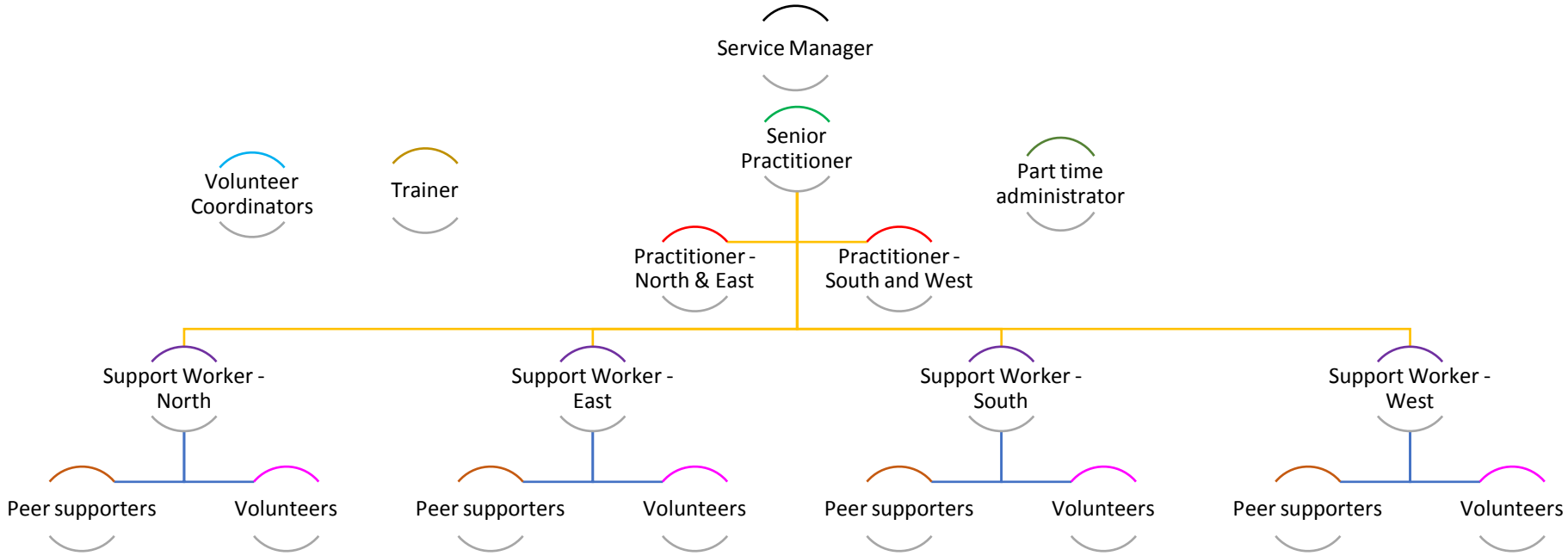
- The Listening Service is a 1-1 telephone support service staffed largely by volunteers.
- The Visiting Service is a home visiting service staffed largely by volunteers.

The third and, possibly, final year of the project will incorporate a TOML tour of the UK to disseminate learning and expertise to services in 10 cities around the UK. This tour has not yet taken place and is not part of this evaluation.

2.4 The TOML team

To deliver these services, the TOML Project currently maintains a team of nine paid staff and 27 volunteers or peer supporters. Figure 2.2 (below) illustrates the composition of the TOML team.

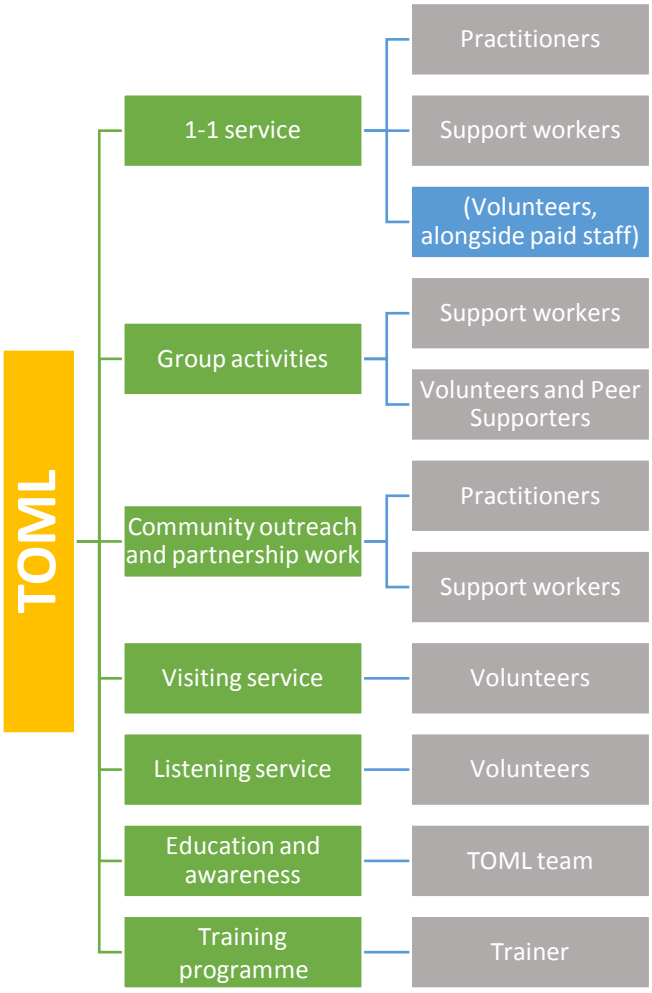
Figure 2.2: The TOML Staffing Structure



The Service Manager manages a number of specialist services including the TOML service and the young people's service. The Senior Practitioner is effectively the project manager with supervisory responsibility for the team. The practitioners take lead responsibility for the 1-1 support and, as the more senior and experienced team members, support people whose needs are particularly complex as well as working with family members. They work across two of the City's quadrants. They also have oversight of other TOML activities particularly those facilitated by the two support workers assigned to working in the quadrants they cover. The trainer is a dedicated TOML trainer and provides training both internally to volunteers and staff on alcohol and older people, as well as to external providers of services ranging from the police force and fire brigade staff to health and social care students and care home staff. The Volunteer and Peer Support Coordinators are not specific to the TOML service but provide volunteers and peer supporters to the whole Aquarius service including the TOML project.

Figure 2.3 illustrates the key components of the TOML service and which combination of the team members delivers each component of the service.

Figure 2.3 – TOML service components and staffing responsibilities



The TOML service has developed and evolved from a recognition of need within Aquarius' service through a research and scoping exercise and a subsequent pilot project. It is clear from discussions with staff that the learning and evolving nature of work with alcohol and older people continues.

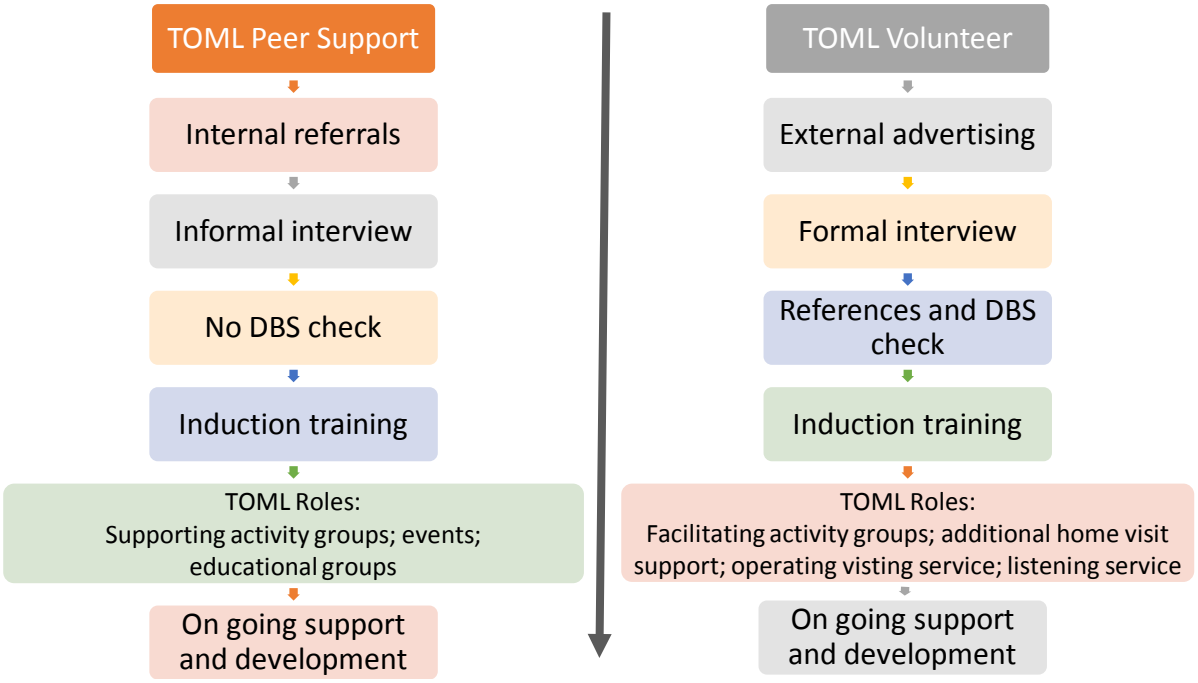
2.5 Volunteer and peer support service

Given the small size of the team to cover a large City, volunteers and peer supporters are an important resource for the service, allowing it to support more people than would otherwise be possible. At the time of the evaluation, there were 27 volunteers and peer supporters active within the TOML project, with an additional 15 registered but not active.

The key difference between volunteers and peer supporters is the range of activities they are involved in and that volunteers may not have come through the service nor had problematic substance or gambling behaviours. Volunteers are formally recruited, interviewed and their backgrounds checked with the Disclosure and Barring Service (DBS). Peer supporters are not formally recruited nor DBS checked in the same way. They usually come from within the wider Aquarius service as current or former clients of the service. The range of TOML activities they are involved in also differ with peer supporters offering assistance at group activities and events while volunteers may facilitate groups, and operate the visiting and listening services. Peer supporters are unable to take part in 1-1 work.

Some peer supporters will move on to become volunteers however volunteers are recruited externally as well as internally to Aquarius where appropriate. Figure 2.4 below shows the differences in recruitment and activities for volunteers and peer supporters in the wider Aquarius service.

Figure 2.4 – Recruitment and employment process for Peer Supporters and Volunteers.



Further information about the volunteer and peer support service can be found in chapter Z below.

2.6 Summary

The TOML service model has been informed by a community-oriented consultancy project and a pilot project. This thorough grounding has resulted in a model that is flexible and responsive and a team which appreciates the importance of this approach. It was apparent that this is an ongoing and dynamic process, and that the team and project would develop and change shape to meet changing needs and to build on their learning.

The volunteer and peer support service is a key element of the TOML service model. The model demonstrates good practice organisationally both in terms of recruiting volunteers but also in supporting people to progress from their own problematic substance use to contributing to the project as valued staff in their own right. Individual peer supporters and volunteers are also able to model what 'recovery' may look like to people they support.

Chapter 3: Methodology

The following chapter provides an overview of the methodology used as part of this evaluation.

3.1 Realist evaluation framework

Realist evaluation rejects simplistic notions that evaluation can discover 'what works' and that a simple cause can be distinguished in the course of an evaluation. Realist evaluation is about "theory testing and refinement" in so far as it identifies hypotheses of why an intervention or programme may work, for whom it may work and why – these features are all part of the evaluation framework (Pawson and Tilley, 2004).

Realist evaluation allows for the nuances of service delivery to be understood in the context of the environment in which they are being delivered. A realist evaluation framework was therefore adopted for the evaluation of TOML in order to capture the components that underpinned the service delivery as well as components that supported its success or were barriers to it.

Pawson and Tilley (2004) identify three key concepts that link together to comprise a realist approach to evaluation. The first of these is *context*:

> Realism utilises contextual thinking to address the issues of 'for whom' and 'in what circumstances' a programme will work. … For realism, it is axiomatic that certain contexts will be supportive to the programme theory and some will not. … Depending on the nature of the intervention, what is contextually significant may not only relate to place but also to systems of interpersonal and social relationships, and even to biology, technology, economic conditions and so on. (p.7/8)

The second concept is *mechanis*ms:

> Mechanisms describe what it is about programmes and interventions that bring about any effects. Mechanisms are often hidden, rather as the workings of a clock cannot be seen but drive the patterned movements of the hands. … In fact, it is not programmes that work but the resources they offer to enable their subjects to make them work. … Realist evaluation begins with the researcher positing the potential processes through which a programme may work as a prelude to testing them. (p.6)

The third concept is *outcomes*:

> Outcome-patterns comprise the intended and unintended consequences of programmes, resulting from the activation of different mechanisms in different contexts. Realism does not rely on a single outcome measure to deliver a pass/fail verdict on a programme. (p.8)

And finally, realist evaluation brings the three key concepts together in the concept of *CMOC*s or "context-mechanism-outcome pattern configurations" which "comprise models indicating how programmes activate mechanisms amongst whom and in what conditions" (9).

This evaluation used an adapted version of this more prescriptive approach. We did not formulate theory or hypotheses linking mechanisms, contexts and outcomes to 'test' in this evaluation. As TOML is one of only a few specialist programmes nationally focussing on alcohol and older people, this evaluation needed to combine an exploratory approach with the realist framework. The TOML project had been running for less than one year at the start of the evaluation, therefore the evaluation needed the scope to identify key features, and reflect the dynamic process of project development for a new type of service. In this sense, this more exploratory approach was closest to Pawson and Tilley's (2004) first phase of realist evaluation whereby a range of data sources, including interviews or document analysis are used to help formulate what they call "programme theories".

However, the realist evaluation framework influenced the aims and objectives of this evaluation as well as the nature and range of questions posed. Further, it ensured a contextual understanding of the findings and their implications for the wider dissemination and application of the TOML model.

3.2 Aims and objectives

Adopting the realist evaluation framework, the research aims and objectives in relation to the three key areas of context, mechanisms and outcomes were as follows:

Context:

- What were the impact of recent commissioning changes on the TOML project and management, for example, target numbers and service criteria?
- To what extent have wider societal influences, such as Government policy on substance use service delivery or the UK's ageing population, affected the TOML project design and delivery?
- To what extent are the project's activities sustainable beyond the end of the project?

Mechanisms of programme implementation:

- In what ways does Aquarius's new service model differ from 'practice as usual', particularly in relation to assessment and intervention processes?
- What do service users see as the TOML processes that helped them to make changes in their drinking/lives?
- What lessons have been learned about service delivery to this particular group of people, their families/carers and professionals during the first year of delivery?

Outcomes:

- To what extent has the project changed minds, skills and practice among the

substance specialist staff providing services to older people with problematic alcohol use?

- What are the experiences of drinking behaviour/lifestyle change among a) service users, and b) families and carers who have been/are receiving the different elements of the TOML programme?
- How effective has the training programme been in changing individual practice and organisational culture?
- What can be ascertained about the cost-effectiveness of TOML service?

3.3 Service user involvement

Evidence about the benefits of service user involvement in research (e.g. Reed et al, 2006; Frankham, 2009; Littlechild et al, 2015) led to the project adopting a participatory approach in seeking to answer the research questions. In particular, it was felt that involving service users in the interviewing of service users and the interpetation of their reported expereinces would put participants at ease, increase their openness and faciltate interpretation that remained faithful to participants' experiences.

A job description for service users was drawn up and circulated via a Midlands-based service user research network in Birmingham (Suresearch). Applicants were interviewed by two members of the research team. Two service users were recruited as research assistants following this process. Both service user research assistants had previous research experience, saw themselves as 'older people' and had experience of using mental health services, though not substance use services specifically. They participated in a wide range of research tasks, including designing research tools, undertaking observations, leading focus groups, interviewing service users, analysing focus group and interview data, and writing sections of the final report.

3.4 Sample population

As documented in Chapter 2, TOML is a complex project, encompassing a number of different strands which the research sought to investigate. The sample population included:

a) Direct users of TOML services, that is, older people who had used or were currently using one or more of the services provided by TOML;
b) Carers (family or friends) who were receiving some form of support from TOML;
c) Volunteers and peer supporters who were helping to deliver one or more TOML services;
d) Paid TOML staff, including managers, practitioners and support workers;
e) Professionals/practitioners from other organisations who had received training from TOML;
f) In addition, the evaluation investigated documentary records and statistical data to ascertain what could be gleaned about the cost-effectiveness of TOML project.

3.5 Data collection overview

In order to gather the views and experiences of the sample population outlined above, there were a number of distinct components of data collection.

3.5.1 Service users

i. Observations of activity groups for service users were undertaken to help the research team understand how the groups were run and the dynamics within the groups. The plan was to observe one activity group in each of the four quadrants, with these groups being selected to represent a range of different group types (i.e. a coffee morning, breakfast club, art group and gardening group). In practice, some changes had to be made to the plan and some different groups were observed to those originally selected, for reasons explained further in Chapter 5a. Four observations were completed.

ii. A focus group with activity group attendees was planned in each of the four quadrants of the city. These were selected to represent different types of groups and to avoid duplication with the groups selected for observation. As with the observations, the original plan had to be amended for practical reasons (explained further in Chapter 5a) and it was only possible to carry out three focus groups. These involved a total of 15 service users.

iii. Individual semi-structured interviews were planned with 25 current or former service users. TOML staff provided an anonymised database of all users of the service since it began. From this, the research team selected service users to invite for interview based on two timeframes, Year 1 (01.04.14 to 31.03.15) and Year 2 (01.04.15 – 30.09.15). This would incorporate service users who had accessed the service early in the operation of TOML as well as those who had received the service more recently and those who remained current users. The initial plan was to select one month within each time frame and from that data set to interview 5 service users from Year 1 and 20 service users from Year 2, ensuring that in both time frames, all four quadrants were represented and that a range of service use critieria were also represented.

For Year 1, service users were selected if they had accessed the service on a minimum of two occasions and if they represented one of the following criteria:

- successful completion of the service in Year 1
- continuation of the service into Year 2
- withdrawal from the service.

For Year 2, the sample were selected to include service users who were accessing at least one of the following services:

- one to one support from a practitioner

- one to one support from a support worker
- a group activity
- the volunteer listening or visiting service or peer support.

In addition, the selected sample included those who were receiving at elast two different types of TOML service so that service users who were receiving a higher intensity service were represented.

However, when service users were selected from one month in each timeframe, an insufficient number consented to interview so further months were sampled in the same way. When this still yielded insufficient positive responses, all service users from both years were invited for interview, with the exception of any who were excluded by Aquarius staff on the basis that it would be inappropriate to interview them. This gave a total of 91 service users from Year 1 who were invited for interview (out of a total of 106) and 98 service users from Year 2 who were invited for interview (out of a total of 106). Of these, 10 service users from Year 1 and 12 service users from Year 2 were interviewed (i.e. 22 in total).

3.5.2 Family and friends

Potential participants to take part in a focus group for family and friends of TOML service users were identified by TOML staff and volunteers based on their knowledge of those they had supported. Participants were drawn from the north quadrant of the City[4]and invited to attend by TOML staff, who sent them information about the evaluation supplied by the research team. A focus group for family and friends was first held in November 2015. However, only one person attended so this was conducted as an interview instead. A further family and friends focus group was arranged in April 2016 and this was attended by four people. Further details are given in chapter 8.

3.5.3 Volunteers and peer supporters

The plan was to conduct four focus groups for TOML volunteers and peer supporters, with separate groups for volunteers and peer supporters. However, the small number of peer supporters and lack of considerable distinction in practice between their role and that of volunteers led to a revised plan to conduct mixed groups. The volunteer coordinators sent information about the evaluation to all current volunteers and peer supporters (n=27), along with an invitation to attend a focus group. The date was selected to accommodate as many as possible of those who expressed an interest in participating. However, only seven of the 27 volunteers and peer supporters attended. Given the smaller than anticipated numbers of volunteers and peers supporters, additional focus groups were not required.

3.5.4 TOML staff

Telephone or face to face interviews were carried out with all TOML project staff, including

[4] A consequence of the active recruitment of family members by a practitioner and support worker covering the North quadrant.

the external trainer and relevant head office staff who had project responsibilities. Twelve staff were interviewed in the first few months of the evaluation and 10 were re-interviewed in the latter stages including four new members of staff. This enabled the collection of data reflecting how views and experiences may have changed during the previous 12 months.

3.5.5. Recipients of TOML training programmes

The two main training programmes delivered by TOML – a more general training for service providers and a separate programme for substance specialist workers – were evalauted using a survey tool available in paper and online. The focus was on the extent to which the training programmes had changed the attitudes, skills and practice of those who participated. Data was collected at three different time points: prior to the training (Time 1); immediately after the training (Time 2); and three months after completion of the training (Time 3). A total of 364 questionnaires were completed in Time 1; 376 in Time 2; and 53 in Time 3. Further details of this component of the evaluation are given in chapter 10.

3.5.6 Economic evaluation

An additional component of the evaluation, not included in the original bid, was an evaluation of the cost-effectiveness of the TOML project. A form of economic evaluation known as 'break-even analysis' was conducted. This is a form of evaluation in which the costs and potential benefits of the intervention are determined in monetary terms, but the scale of the benefits are not able to be estimated (for further details see chapter 11).

3.6 Research tools

Participant information sheets, interview schedules for the service user and staff interviews, a topic guide for the focus groups and a template for recording the observations were all discussed by the research team, with drafts circulated and amended until all members approved the final versions.

The interview schedule and topic guide outlined areas to be covered and possible prompts, but they were not intended to be used as a rigid or restrictive structure. Rather, researchers were clear that the aim was to engage in conversation with participants, creating an open and relaxed interview environment. The interviews were semi-structured, combining a pre-defined focus with a measure of flexibility and responsiveness to the individual experiences of participants (Arthur and Nazroo, 2003). This meant that researchers were free to prompt or probe as seemed relevant to the particular interview or focus group; equally, interviewees were encouraged to discuss issues which they felt to be relevant, outside of the questions listed in the interview schedule or topic guide.

Consent forms for service users and staff who were interviewed and for service users, family and friends who participated in focus groups were also discussed and agreed by the research team.

The questionnaire for collecting the training evaluation data was developed by the principle

investigator and team member with responsibility for this strand of the project. It was piloted by six members of Aquarius staff as well as health and social care professionals external to Aquarius.

3.7 Data analysis

All interview and focus group data were audio recorded and then fully transcribed using a professional transcription service. The qualitative software computer-based package, NVivo v10, was used to aid the development of codes and themes. The coding and categorising of data followed the approach of developing an analytic hierarchy, that is, of moving from data management (generation of themes) to descriptive accounts (assigning meaning) to explanatory accounts (developing more abstract concepts) (Ritchie et al, 2003; Spencer et al, 2003). This began with the identification of first-level codes; these were then grouped into categories and then synthesised within thematic domains. One member of the research team took the main responsibility for coding within each strand of the project, but in each case a second team member undertook cross-checking, verification and refinement of the codes and themes.

These themes were then mapped onto the different components of the programme, e.g. group work, family work. This enabled different perspectives, such as service users' or professionals' perspectives, to be grouped together to avoid duplication and to allow for a more rounded discussion on each component of the service. A number of themes did not speak directly to the TOML model, nor to the aims of the evaluation, and have not been included in this report.

The quantitative data formed the main part of the training evaluation. Quantitative data were analysed using descriptive and bivariate statistics (i.e. correlational analysis) according to the research objectives. Inferential statistics that included multivariate analysis, namely hierarchical regression models, were computed to determine the extent to which characteristics of service users, family/carers, professional and organisation were associated to experiences of drinking behaviour/lifestyle among service user and families who have been receiving TOML programme. Further parametric tests, that include Repeated Measure ANOVA, were used to explore the changes in attitudes, skills and practices of professionals across different time points following the programme. Specifically, the computer software Statistical Package for Social Sciences (SPSS) was used to carry out these analyses.

The economic evaluation adopted a 'break-even analysis''. This is a form of evaluation in which the costs and potential benefits of the intervention are determined in monetary terms, but the scale of the benefits cannot be estimated – perhaps because of lack of appropriate data. In this case, the results of the evaluation address how great a change is required as a result of the intervention so that there is confidence that costs can be covered.

3.8 Research ethics

Ethical approval was obtained from Manchester Metropolitan University Faculty of Health, Psychology and Social Care Ethics Committee on 16 July, 2015 (Ethics Application 1295).

Full written information about the evaluation and what participation would involve was provided to all participants – staff, external training participants, and service users - prior to their involvement. This clarified the grounds for consent, confidentiality and anonymity, including the circumstances under which confidentiality would be broken. Everyone was given a chance to ask questions prior to giving written consent.

The research team were sensitive to the potential vulnerability of some service user participants in particular and it was agreed with TOML staff that they would approve approaches by the research team to individual participants before these took place. In some cases, TOML staff made the decision that it was not in individuals' interests to be invited to participate and these people were then excluded from the study.

During observations of group activities and focus group discussions, the researchers were mindful of the importance of the activities to participants and sought to cause minimal disruption to the normal processes. Researchers joined in activities where appropriate when carrying out observations and timed the focus group discussions so that these took place after the main activities.

TOML staff and volunteers who were present at group activities were asked to absent themselves during focus group discussions in order to ensure confidentiality for participants. However, it was made clear that any issues that indicated a risk to the safety or wellbeing of participants or others would be communicated to staff. In one focus group, some potential participants were not happy about this and chose not to join the focus groups discussion. Service users who were interviewed were invited to choose their preferred location for the interview. Most chose to be interviewed at home but some chose to be interviewed at a venue used for TOML activities or in a neutral location, such as a local community venue.

3.9 Limitations

The scope of this evaluation was limited to a 14 month period starting in year two of the three year TOML project. It should not, therefore, be taken as an evaluation of the whole project. Effectively it covers year two of the project and the start of year three.

Access to all service user participants was through TOML project staff and the research team were reliant on them to ask service users for permission for the researchers to make contact and to pass that information to the research team. The research team is aware of a small number of people that staff felt were not appropriate to contact. However, of the remaining service users contacted, the research team does not know how many people said they would not take part or how many simply did not respond. The research team is aware of only one respondent who wanted to take part but whose details were not passed on to the team.

In some of the individual interviews with service users, it was apparent that they were very grateful to Aquarius for the support they had received from the service. In many cases, the request to participate had been made directly by their support worker and they saw agreeing to take part as a way of 'repaying' Aquarius for the help they had received. This may have led to a positive bias in terms of the evaluation of the service, with more people positively oriented to the service taking part and being inclined to express positive views. However, this motivation in itself reveals something about the degree of gratitude and loyalty felt by service users towards the service. We were also unlikely to have captured the views of people who are still working.

The focus groups resulted in far smaller numbers than anticipated. This may have been due to the smaller number of people attending groups or people's unwillingness to be part of the evaluation. The findings, as commonly occurs, represent only those who were willing to come forward as participants and it is feasible that a range of different and conflicting views and experiences may be held by those who did not take part.

The professionals were all willing participants and appeared to fully support the evaluation process. During the course of the evaluation a number of staff left or changed roles and therefore were unable to participate in the time 2 interviews.

Chapter 4 – How the TOML model differs from practice as usual

Key messages

- The TOML model is grounded in an understanding of the different treatment and support needs of older people with alcohol problems.
- It offers a holistic approach which enables staff to respond to the person's needs beyond the alcohol intervention, e.g. social isolation, health and welfare support, but which are often related to it.
- Service users have mixed views about the benefits of an over 50s service specifically – some are in favour and others feel it should be available to all ages.
- TOML provides a flexible and responsive model with accessible staff and no rigid deadlines for service receipt.
- There are a range of services available in a number of different locations across the City, which allow for a 'mix and match' approach to be offered to service users.
- Partnership working has been built in to the model from the start to ensure people's wider needs are met.

4. 1 Introduction

One of the aims of this evaluation was to explore how the Aquarius Time of My Life (TOML) service differs from 'practice as usual' within Aquarius. In particular, it sought to explore the nature and extent of differences in relation to assessment and intervention processes.

The following findings draw on data from both professionals' and service users' perspectives as well as those who are volunteers and peer supporters within the TOML service. In order to preserve different perspectives data were analysed discretely for each group and their views and experiences are presented seperately below.

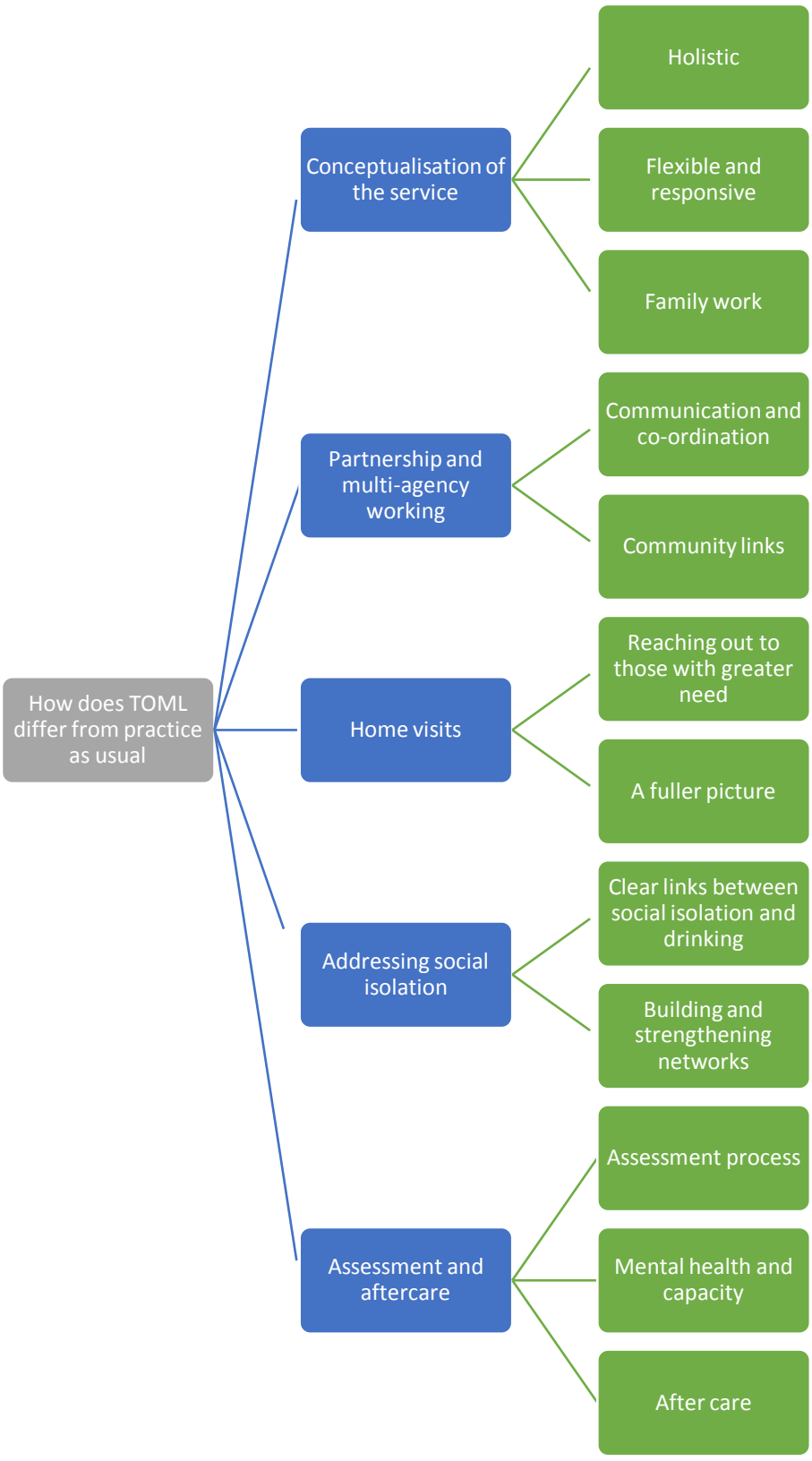
4.2 Findings: professionals' perspective

Analysis of data from telephone or face-to-face interviews with TOML staff (see section 3.5.4 for methodology) identified five main themes that were relevant to this research question:

1. Conceptualisation of the service by staff
2. Partnership and multi-agency working
3. Home visits
4. Addressing social isolation
5. Assessment and aftercare

The themes and sub-themes that relate to this question, and that are discussed below, are summarised in Figure 4.1.

Figure 4.1: Professionals' perspectives on how the TOML model differs from usual practice



4.2.1 Conceptualisation of the service by staff

Holistic

Without fail staff described the model as doing more than addressing the person's alcohol problem or delivering an alcohol focussed intervention. There was a clear sense that the delivery of the TOML service went beyond normal service delivery. The common terms used by staff to describe the approach included 'holistic', 'whole person', 'community-based' supplemented with examples of what that meant:

> I think what works well is the staff have signed up to community-based services, they're signed up to going out to people's homes, so the way that the service addresses the whole person, not just the alcohol, they don't see the alcohol in isolation, they're looking at the circumstances of the whole person and how that person is drinking and affected by their environment and the alcohol and what could be put in place to help and support them? (TOML staff member 10).

> I think because it's embedded within the community, we offer one to ones, groups, we work with family members so it's holistically looking at the family and not just the person who's using themselves. I think because we don't just look at the alcohol, we look at that person's journey (TOML staff member 9).

> We also look at such things as their housing, their benefits, trying to get back in touch with family who they may have not been in touch with who have moved away and have isolated themselves a little bit. So it's more about more of a holistic viewpoint, getting them into a good place so that they are feeling more confident and more capable of knowing what to do, should the circumstances bring them to a place where they might be tempted to drink again (TOML staff member 3).

The professionals commented on the longevity of drinking histories for many of their service users and the need to work with people on their lifestyles in order to affect or support changes in their drinking. This included supporting people to integrate into their communities better, to get out of the house and reduce social isolation, to support them in addressing their housing or financial problems.

Flexible and responsive

TOML staff described the service as being more responsive to people's needs than other services. Some staff said this was because of the nature of the client group and the range of needs to be addressed in order to affect change in their drinking behaviour; others described it as the approach needed to ensure people engaged with the service while retaining their autonomy:

> I think with generic Aquarius there is [sic] time limits of certain support. With Time of My Life we have a bit more of a softer approach because we

> can't set something for 12 weeks or something because it could take a lot longer… (TOML staff member 2).

The flexibility afforded to TOML service users to stay in services longer than the standard 12 weeks was highlighted by the volunteer and peer supporters' focus group too.

> A lot of people don't do it in that time, it goes on. But with Time of My Life, it's slightly different in as much as that we're looking at people who are maybe not drinking but at risk … with loneliness and isolation, stuff like that, the groups are trying to get people, to help people who feel isolated and lonely and to stop them going into possible substance abuse (Volunteer and Peer Support focus group member).

Having more time than usual for treatment services was identified by a number of staff as key to service delivery. Having more patience and a willingness to support clients in other areas of their lives were prerequisites to giving people more time:

> We've got more time with the clients. A lot of organisations have a set amount of time for the client and that's it and if it doesn't work then it's the end of it and then you've got to start all over again. (TOML staff focus group member)

> We are able to give time to people which is important and that's a big thing. … Obviously there's time constraints, like with anything there is, but you have got a bit of freedom to work with a person. Know them, engage them, get to know them, which is important … (TOML staff focus group member)

One staff member stated it was a slower process working with older people than might be usual:

> …they tend to be more quieter on the phone and speak slower so it would physically take longer to take the referral from them. ... sometimes we find that they just want to chat …. So, a more in-depth conversation you seem to have with the Time of My Life project's referrals on the phone particularly. (TOML staff focus group member)

The flexibility and responsiveness of the TOML approach was also highlighted in terms of persevering with people who may usually have been discharged or cases closed or transferred elsewhere:

> So in treatment services, people can DNA and they'll get a letter, I think this cohort, the team don't really let people DNA, they kind of track them and I think that makes the difference. So engagement can be harder but this team really stick at it and I think that makes a difference as well. Not like two appointments and then you're out. (TOML staff member 11)

> I had a client … and I initially saw him in hospital, then although I would have referred him to the other side of the city because he falls on the border of east [quadrant], he would have been with a different worker. Because I'd been working with him in hospital, because I'd got that relationship and rapport with him, it made sense for me to keep him… (TOML staff member 5)

Related to this responsiveness was a commitment to principles of empowerment and supporting people through the TOML approach to 'make better choices'. This was explained in terms of methods of working as well as the values that underpin the approach which are geared towards helping people to move on with their lives post TOML intervention:

> [The TOML approach] allows people to feel as if they've got, it's about them having the power and the confidence to know they're in charge, they're leading what they want to do. We're giving them advice and information and we're giving them strategies and also helping them to make good decisions but they know that they're the ones who actually are leading the process, in the direction that they want it to be. (TOML staff member 3)

> It's to support, help and empower the client, to lead a better life and to be able to make informed decisions as to the choices they make in regard to their alcohol usage and their general health. (TOML staff member 5)

Staff very clearly conceived of the TOML approach as a much wider and more inclusive service that sought to support the person in many areas of their lives which related to their problematic alcohol consumption. While services were still delivered at an office base, the ability to work in the community and in people's homes appeared to be an important feature of this service in supporting the identification of, and response to, the wider issues affecting people's lives.

Family work

Working with family and friends was another theme that emerged as part of the TOML service approach. It was presented as something that Aquarius does anyway as part of its standard service delivery but it was highlighted as an important part of the TOML model. Staff identified two roles of family members, one as service users in their own right but also as a support team for the individual:

> The time that I do work with family and carers is if they're in the session at the same time when I'm working with the client, and if the client has said 'yes I want my family to be a part of it' or for carers to be a part of it. I will do a joint kind of session. So if the family or carers do have any issues or any questions I will talk through it with both at the same time… (TOML staff member 7)

> Most projects tend to look at just the people who are affected with problematic drinking, we work with people who are drinking and we'll

> work with their affected others, spouses, adult children, to support them through the process as well… . (TOML staff member 3)

Chapter 8 will explore family work undertaken in more depth and the learning in relation to family service delivery.

4.2.2 Partnership and multi-agency working

Staff identified partnership and multi-agency working as a key component of the service and a way to provide a good service without people being 'bumped' around between a range of services.

Communication and co-ordination

Given TOML's community base and the wide range of health and social care needs of TOML service users, the ability for the TOML project to work alongside other specialists ensured an appropriate service could be provided.

> …there's a lot of conversations that go between myself and the GP or myself and Social Services with the vulnerable adults' team, it's really to get organisations to work together, to have a good link, so if anything was to happen to a particular client or patient, we're all singing from the same hymn sheet, just to make sure they've got the support they need and it's in place. (TOML staff member 5)

In such cases TOML staff became the consistent presence. One member of staff spoke about the importance of older people not being "shuffled" from one service to another with TOML providing that holding role:

> I think in practice, what can happen is that one service moves the client to another service, who moves them to another service, which isn't the best approach for an older person, they just feel they're being pushed from pillar to post. They're less likely to interact anyway because of stigma and embarrassment [about their alcohol use] and lack of motivation, so if it feels more holistic and feels more like a well-rounded approach, they're more likely to engage in a service. (TOML staff member 3)

Building relationships with other health and social care providers was identified by staff as important both for referrals into the service but also for joint working and communication and professional learning:

> So we have our official referrals from GPs, from housing services and social services, the hospitals, from trips and falls teams. We have referrals from a variety, also from the police and the ambulance service. … we've got links with the hospital social workers, the dementia team, the slip trips and falls team… the A&E admissions, the gastro ward, the liver ward, you name it all the different things that go on in hospitals. The RAID[5] teams we're very

[5] Rapid Assessment, Interface & Discharge (RAID) team: a specialist multi-disciplinary mental health

> much linked into, and then from that there's all the ambulatory care and all the different things that go with that, that in varying degrees we have links to…. There's probably 100s of agencies that I've missed, because there's just so many people that we work with … (TOML staff member 1)

> I also think being able to go into a hospital and work with the mental health team, we have very close links with the RAID team and Social Services and that's what puts us apart from other alcohol services because we are able to make these links and can offer these different types of groups, as well as the normal pathways into day centres or AA or whatever. (TOML staff member 5)

Additional services and collaborations included local vulnerable adults safeguarding panels, students from local universities, other specialist substance use agencies, GPs and primary care staff, and local authority local delivery groups.

Community links

Finally, the presence in the community and the building of relationships with community representatives allowed TOML to hold groups in community spaces and explore new venues for group work activities:

> I think being involved with other services like the police, the fire service, like community centres and so forth, we're part of their community, we're not a service that's plucked out of the air that suddenly appears. They hear and see us in their local leisure centre, in the library and different places, so I think those are the things for me that contribute to how [TOML] is effective. (TOML staff member 9)

> I think it's really good that we've been able to kind of go into the community and say, "This is what we want to do, this is what we have on offer, do you have space for us? Can we have your room for free? What would you charge us for a room?" (TOML staff member 5)

While partnership working is part of usual practice for many substance use agencies and for the main Aquarius service, the TOML project staff were presenting a picture of more active and assertive partnership arrangements – particularly with hospital-based health care staff and welfare organisations. This appeared to stem from TOML staff identifying more clearly the multiple needs of this group of older people and the need to support them in addressing these needs first (in some cases) in order to be able to address the problematic alcohol consumption. While this approach could be used in office based interventions, there was a clear sense that the staff member's physical presence in the person's home and community, and all this entailed in terms of meeting family members, building relationships outside of a 'clinical' setting, enabled a more personal and trusting relationship to develop and co-existing issues to be identified.

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service.

4.2.3 Home visits

Staff reported home visits as an important component of the TOML service. Given the time and resource implications, home visits are not a routine mode of service delivery within substance use services, but staff reported a range of advantages to home visiting.

Reaching out to those with greater need

Staff saw one advantage of home visits as ensuring that the service can be received by older people who are less physically mobile and those whose mental health has led to their increasing social isolation and lack of confidence in going out of the house.

> … one of the things which has come up is all about home visits as well, some older people, they can't easily get out or they're not confident about getting out and the home visits seems to be one of the things that is really important, or making sure that where we're offering the service, is somewhere that older people feel comfortable about going to and it's easy to get there as well. (TOML staff member 11)

> That's where our service differs from quite a lot of other services because we are able to go out and we have the time to spend with them, at their homes because they can't get elsewhere, so it does take a chunk of our day up with travelling but it's something that we need to do because it's something other services don't offer. (TOML staff member 5)

A fuller picture

Some staff reported how seeing people in their home environment enables a fuller assessment of need, including meeting family members and engaging, in some cases, with neighbours and the community.

> Also if I go to someone's house I can see their living environment, if some people are having problems at home that they might not talk to you… you may not ever know about if … but you can see that environment, whether they're eating properly, the hygiene of the place, the state that it's in. Things that could be a problem for them. So you do get a better idea of everything about that person from just where they live. (TOML staff member 4)

> Also working with people in their own homes, seeing at the first-hand what the difficulties were, what the issues were and what that did as well opened up the extended family accessibility because families were interested and really jumping on the fact that I was going out to people's homes and wanted to be involved, feeling more supported because very often families feel very unsupported and at a loss as to know what to do …. (TOML staff member 10)

> There's no façade really as such. There's no pretending, because you go to a home visit and you catch people in positions that sometimes they try to pretend that they're not in. (TOML staff member 9)

In particular, the home visiting had, on occasion, enabled workers to advocate for a multi-disciplinary service that a service user had previously been refused because the service provider had not seen the service user's home environment and did not believe the extent of the person's needs.

4.2.4 Addressing social isolation

The pilot study (see chapter 2) highlighted the need for the TOML project to identify and address social isolation and to support people to "actually join the world again because a lot of the people, they'd lost all their confidence, they felt ignored, they felt invisible and very often, the only people they saw were the emergency services. It was trying to get people back engaged within social interaction in the community" (TOML staff member 10).

The importance of this aspect of the service was repeatedly highlighted by staff working on the TOML project. Its identification as an important feature of the service was clearly borne out in service delivery.

Clear links between social isolation and drinking

Staff perceived there as being a direct connection between experiences of social isolation and problematic alcohol consumption:

> We look at a lot with triggers, memories, bereavement. I find with the over 50's, loneliness and isolation, the neighbours have moved away, the kids have gone, partners have passed away, the pets have died and the only family they have is the alcohol. (TOML staff member 2)

> A lot of our clients suffer from social isolation which leads to their drinking, that leads to other issues that that may cause in life, so I feel that at the support level through our groups we can offer them quite a bit of help and wellbeing in a way to help them overcome that social isolation, (TOML staff member 7)

Building and strengthening networks

Given these beliefs about the link between social isolation and drinking, building service users' social networks was seen as an important component of the service.

> ..our service is commissioned and our work is around primarily alcohol and social isolation and so widening people's networks, not just their family networks and their support networks generally, in terms of friends and the community , but also in terms of other professionals who may be better suited once we've completed our part of the work, to then continue to support people (TOML staff member 9)

> A lot of the people we work with are socially isolated, feeling very lonely, feeling quite depressed, have a lot of life changes, bereavement, so actually getting back into the swing of actually having social interaction outside of the home and not actually just working with professionals, social

> workers, hospitals, doctors, is actually getting back into the swing of being part of everyday life again, which also adds to their confidence. (TOML staff member 3)

Undoubtedly, the TOML service staff felt their role was two-fold, i) addressing the alcohol issues and ii) the social isolation, and that the two were inextricably linked for many of their service users. Some of the social isolation was addressed by groups work and activities, but the contact with the service staff (paid or volunteers) was also a way of supporting people to gain confidence, build resilience and encourage people to attend other activities in the community, such as library visits or taking a course.

4.2.5 Assessment and aftercare

Assessment process

Staff reported that the assessment process for TOML differed primarily in the approach staff took to undertaking the assessment rather than the tools they used. Importantly the assessment form was not administered in the same way that it might be used in the main service:

> …to be assessed isn't a normal thing with our older adults, they're not used to being assessed. So sometimes the first session which in general Aquarius work would be an assessment, although we'd like it to be an assessment, sometimes it's a relationship building, getting to know this person, what they want from session before they whip out an assessment form. Because if you do, they'll be out the door because they're not used to it. (TOML staff member 1)

> I think it's about a gentler approach really… very often older people will get very cross if they think that they're being patronised or they think they've got this young person coming in and asking them very personal questions, which a lot of the questions we ask are very personal, so it's about making sure that you've set the scene and you've got enough of a relationship to go into those questions, … (TOML staff member 10)

> I think it is about having a broader assessment framework, I think it is about having staff who are good at engagement, good at listening and empathise well with this cohort. (TOML staff member 11)

Staff report that the assessment is still completed but the emphasis is on identifying a range of needs through a more conversational approach and asking the service user which they wanted to focus on first. This is somewhat different from usual practice where an office-based individual intervention would focus on alcohol primarily with referrals on to other services as needed. Referrals to other agencies in the TOML approach were much more supported by TOML staff and helped to build the relationship with the service user.

During this evaluation a new assessment tool was developed for use within the TOML service. This was seen as a more appropriate and sensitive tool for assessing the needs of

older service users and as reflecting the more conversational tone required with this age group:

> Our assessments are very different and it's created as an older people assessment tool and that's been really good because the way that they've done it has been a bit like a conversation thing … different ways to ask the question almost so you go through it and you're bringing out more information. (TOML staff member 6)

Mental health and capacity

People's mental health and mental capacity were mentioned by a number of staff in relation to the assessment process, particularly in relation to possible dementia and cognitive problems. They presented a challenge in relation to accurate information about what mental health problems related directly to the person's intoxication and what existed in conjunction with it and could be more accurately assessed if the person was sober. Other services were often unwilling to take people on without knowing what belonged where:

> We've got this client, we're concerned because, for example, we believe there is some underlying mental health and memory issues but because of the alcohol, we're getting pushed back from vulnerable adults [service] saying they're not willing to accept it because they're making a choice to drink and they can't diagnose. (TOML staff member 9)

Additional information and support from family members or friends was also found to be particularly helpful at the assessment stage with older people, either to fill in the gaps of information or to simply have contact with someone nearby who can check on the person if needed.

After care

The TOML service was seen as different in relation to its attitude to closing cases or 'discharging' service users from the service.

> …people can stay within the service and access different aspects of the service and don't have to be in support, as in structured support, to still be receiving support. There's much more of an after-care element and a recognition of, for example, the social isolation with older people and supporting that to prevent relapse. (TOML staff member 9)

> I mean they're not necessarily open with us anymore… I've got a man who hasn't had a drink for months now and he's doing really really well but he just likes the visits because he likes someone to talk to so what they're doing is ... we're now setting up the befriending service which is when they actually do the visit, a volunteer will come and take over that from me basically. (TOML staff member 6)

The peer supporter and volunteer service within TOML allows people to stay connected with the service if they wish as this is one of the progression routes through the service:

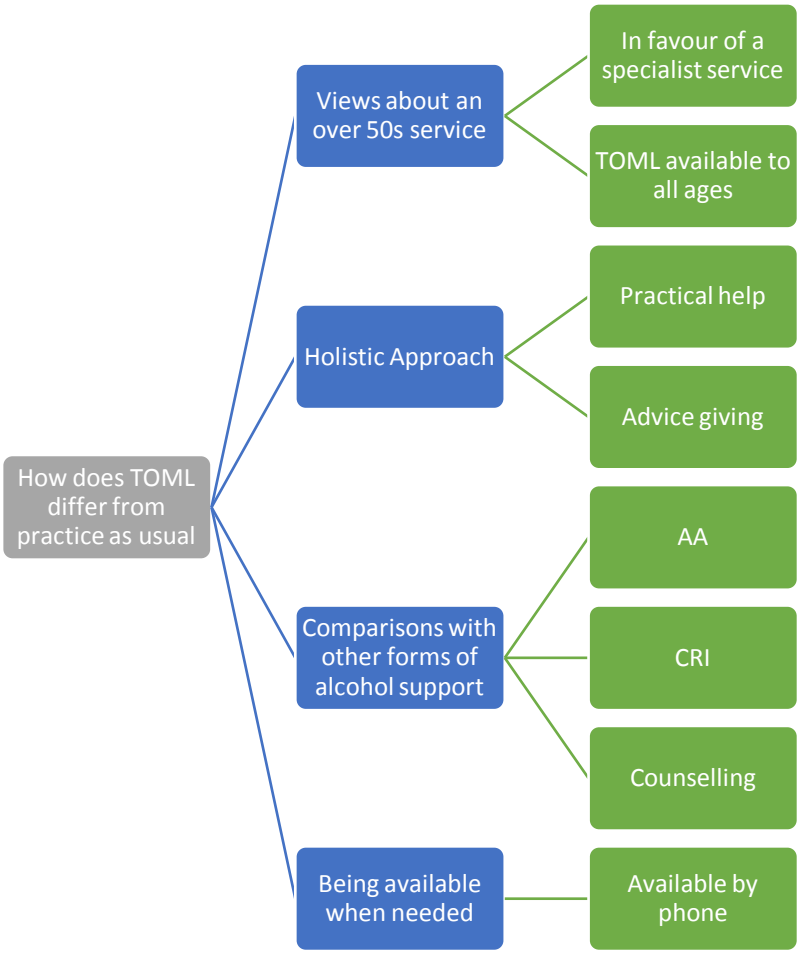
> Even in our groups we have some of our clients/service users that come in there to help us put things together for our newsletters, so we do try and keep them involved as much as we can. If the service users do feel that they've finished their time with us and they're happy, they're abstinent, we could offer them the peer mentorship, we could offer them volunteering if that's what they want to do, which I think is a massive positive because then they're still in the process. Again, it's just building up that rapport, isn't it? (TOML staff member 7)

While substance use services will differ in what they offer and how they do it, historically the majority of mainstream services have operated on a 1-1 intervention basis, from an office base, with limited time both for individual sessions and for the length of time people can remain with the service. Both groups of professionals and volunteer/peer supporters identified key features they felt went beyond 'practice/treatment as usual' and, in doing so, provided TOML with a different model of service provision.

4.3 Findings: service users' perspectives

The interviews with service users (see section 3.5.1 for methodology) did not ask participants directly how they perceived TOML to differ from usual practice as it was assumed that not everyone would have a frame of reference from which to respond, particularly if they had not accessed alcohol services previously. However, a number of questions in their interview schedule asked directly about particular features of the TOML service. The analysis resulted in four themes that speak to how TOML practice differs (see Figure 4.2 below).

Figure 4.2: Service users' perspectives on how the TOML model differs from usual practice



4.3.1 Views about an over 50s service

Participants were asked about their thoughts on the usefulness of a specific service for people over the age of 50s. Some people were unaware that TOML was an age specific service, but most participants offered some thoughts. Responses fell into two main categories: in favour of the age specific service and not against it but wanting the TOML way of working to be available to all ages.

In favour of a specialist service

Some participants appreciated contact with those of a similar age group which the TOML service offered and contrasted this with being with young people:

> … if you had a bunch of teenagers in there, their outlook would be quite different to what it is when you're a little bit more mature, and you see things in a different light. That is what I found really useful, being with people of a similar age who have gone through difficulties, and they're just nice people but they've come out the other side. (TOML service user 3)

Another respondent spoke of the way in which an age specific service was helpful in terms of recognition that there were other peers with alcohol problems:

> The only thing that I thought of was I'm not the only over 50 that's got an alcohol problem, I'm not the only one. You do tend to think that you're different to everybody else and there's only you that's got this problem. When you realise that other people of the same age group have got that as well, and that there's a service for them it's quite good. (TOML service user 10)

For others, the focus was on commonalities and distinct challenges for the different age groups:

> So over 50s and more specifically people on their own. So work's not a priority, although it might well have been in the past. Like in my case suddenly there isn't something that needs you to get up every morning and no kids to look after. All the other things I've already said really, that makes it a completely different set of circumstances. Or a void that alcohol might push itself into or be welcomed into. (TOML service user 9)

> … life being what it is and life experiences, you're more than likely to start to get some commonality because of the way life takes you when you get a certain age. Example, a group of people in the 50-60 year olds may have lost parents that sort of thing. If they had children, their children have probably moved on and they've done loads of things… (TOML service user 12)

TOML available to all ages

Some participants were neutral about the need for an over 50s service and were concerned about other age groups - particularly teenagers - not getting the support they needed as a result. They felt that other age groups should be able to benefit from the service they had experienced:

> Well I found the approach … as being useful as far as I'm concerned. I could imagine it working at various times of people's chronological age, rather than just over 50s. I suppose some people will have more opportunity to partake in alcohol when there are less financial concerns. (TOML service user 7)

> Time of My Life sounds good but I think it should be for all ages, to be quite honest. (TOML service user 13)

> … I think you get a lot of people in their late teens and 20s who probably drink heavily anyway, and they probably won't when they've reached their mid-30s or 40s. Some will, some won't. But people like myself who continue right through your life and it's just got worse in the last 10 years. It's hard to say. I mean I've got a friend who died at 44 through alcohol some years ago now. … He could have done with the same help that somebody of 50 is getting. So it's hard to say. I'm not saying to have

> groups with people who are 20 and 50 in the same group is necessarily good, I don't know, but where do you have the cut-off point? Do you make it 40, do you make it 50, do you make it 60? I don't know. I haven't got the answers for that. (TOML service user4)

Overall, participants felt there was some overall support for services tailored to differing circumstances related to age, but voiced a need for flexibility so that services were oriented to the individual's circumstances and needs rather than age per se. TOML's work was clearly valued and there was the view that valued aspects of the TOML service should be available to all ages.

4.3.2 Holistic approach

As with the professionals, nine participants spoke of TOML staff spending time helping them with other problems such as debt, housing and health difficulties.

Practical help

The home visits as part of that were clearly valued both practically but also therapeutically because the session was happening in the very place that she drank:

> …this is where I drink as well. So going to Aquarius, although I can see how that works… for him coming here, which is where I actually drink and where I live, I can't explain actually how it makes a difference, but it just does … and he just sits here because I can't sit there anymore. He even sits here where I sit and have a drink and we're talking about me drinking, where I actually drink and I think that helps a lot. (TOML service user 10)

At times TOML staff offered practical help with phone calls or support for housing applications:

> *Participant*: It's about practical ways to stop drinking and he's also helped me a lot with debts as well. I was in a lot of debt and he sorted all that out for me as well…it was still about the alcohol as well, but for the first few times that he came he actually phoned people up and got payments sorted out and other stuff like that.
> *Researcher*: Which takes some of the pressure off?
> *Participant*: Yeah it takes the wondering whether the bailiffs are going to come, it takes all that away… (TOML service user 10)

> I was going to Aquarius every now and again while I was still drinking at the time, I was slowing down on the drinking but as I did stop, he [TOML worker] helped me to get this place through the Trident Housing Association so because I've got these … I'm in a sheltered accommodation flat, self-contained, I'm no longer living in bedsits where there used to be a lot of drugs and alcoholics, so it's a lot easier here to … stay clean and dry, I've never taken drugs but I'm off the drink. It's been one year, 10 months now (TOML service user 18)

Advice giving

At other times staff offered advice on a range of topics. One respondent referred to help with thinking about nutrition:

> They ask me what food I like and what food I do, what food I eat and what food I like, and then they're saying "well why aren't you eating the food that you like", and it got me conscious about, because I never used to think what I ate at all. … I'd just live on meat pies all the time and not think about it, and that didn't help. It doesn't help your organs or anything. Drinking doesn't help your organs. You've got to have veg and everything like that. So Aquarius got me into thinking about my diet, saying, well you know, "you like this, you like that, you get it". (TOML service user 1)

> …there's lots of tips like that that he gives me, not only about drinking but about dealing with things that I do on a daily basis. (TOML service user 10)

A number of other areas in which TOML staff had offered advice and support were mentioned by service users. These included suggesting and arranging various activities with other groups and services such as a befriending service, courses and voluntary work, counselling regarding domestic violence, and Tai Chi classes.

4.3.3 Comparisons with other forms of alcohol support

Participants were asked about their use of others services. Some reflected on differences between these services and the 'Aquarius' service while others viewed other forms of alcohol support as complementary. Participants spoke more specifically about Aquarius than TOML. Three types of support in particular were identified: Alcoholics Anonymous (AA) – a mutual aid organisation, CRI[6] - a mainstream alcohol and drugs agency, and Counselling services.

Alcoholics Anonymous

A number of participants had found AAs approach difficult, due to its spiritual element or its complete abstinence approach. Another found group work difficult and described preferring the 1-1 service model to the group format of AA:

> I've also tried AA, but that didn't work for me. Because it's a group thing and I get quite anxious in groups. I'm okay one to one. And you have to share... So that really didn't work for me. (TOML service user 10)

> It's different for everybody. I think at Aquarius they appreciate that, whereas at AA they seemed to think you just have to stop full-stop, and it didn't work for me (TOML service user 4)

Some people found the disclosure involved in the AA groups difficult. However, at least two of our participants spoke of AA and TOML as complementary. In doing so the structural

[6] CRI has recently changed its name to Change, Grow, Live (CGL). CRI will be used given this was the agency's name at the time of the interviews.

differences they experienced in both AA and Aquarius were highlighted:

> I've got AA of course which I shall still go to… . I do believe in AA, that has been a big part of my life as well, sharing. I think that is a big, big thing as well, the sharing part of it. Which you get with Aquarius. (TOML service user 8)

> So [AA members] will talk about themselves and their past experiences. But there's no programme or nothing like that that they recommend that you go through or anything like that. It's only a meeting between alcoholics themselves and others who are the same, and we share our experiences. Whereas with Aquarius it's a completely different thing, there's a cure and there's help and they're part of the cure Aquarius are. (TOML service user 8)

However, for another respondent, who believed in the need for abstinence, Aquarius' flexibility was seen as unhelpful:

> Yes, [Aquarius] is telling someone they can actually drink, they can't. If you want to straighten your life out and you find out the only time you ever got arrested or picked up or into trouble is through drinking, do you not think you've got a problem with you and the drink? You know, so the answer is don't touch the drink and you won't get into trouble. (TOML service user 6)

CRI

Just one respondent spoke about moving from CRI to TOML. The participant described not knowing what to do when CRI would no longer offer her a service as a result of two previous detox attempts. TOML staff arranged for admission for detox at a local hospital and the assigned support worker visited weekly while she was in hospital (a month due to a chest infection).

The key differences for this participant seemed to be the age specific service and access to one to one sessions:

> I know that when I used to speak to [TOML worker], he said that Aquarius was for my age group, that's why he could take me on from CRI, which obviously was great for me because as I say, I found them a lot more suited for my age than going to meetings with younger people and they also did a lot more one to one which CRI didn't really give me the opportunities to do. (TOML service user 14)

Counselling

Two participants contrasted TOML with counselling services they had found unhelpful. In both cases, the counsellor sought to explore earlier experiences that might have been linked to the problem drinking:

> I think things that have happened previously in my life that actually ...

> She'd try and get me to talk ... I suppose this is the idea of counselling isn't it to talk about it? Talking about it and make it more so that I accept what's happened and then can put it to rest and carry on and not think about it. Maybe that was what was making me drink. But it didn't work. (TOML service user 10)

What appears common to these service users' experiences is the flexibility of the TOML approach in that it does not take a psychodynamic approach or one that pressures people to share their personal experiences or discharge people who have received a set amount of service provision.

4.3.4 Being available when needed

TOML service users also experienced the service as being flexible and responsive which the professionals identified as part of the TOML model.

Available by phone

Ten participants spoke of feeling able to speak to TOML staff by phone when needed and the value of this to them. Service users had mobile phone numbers of staff and could contact them when needed:

> *Participant*: There has never been an incident where I've tried to get hold of somebody and I haven't been able to get hold of anybody.
> *Researcher*: That's quite a security isn't it, knowing that?
> *Participant*: It is because weekends can be so lonely, if you think you haven't got anybody there. (TOML service user 14)

> The initial reduction was hard. I'd like to say there could be a bit more support there but I'm not really sure how he could. The first thing he did was say, 'Here's my mobile phone number. If there's any issues, I'm always on the end of the phone.' There's not a lot really more that he could possibly do apart from move in [laughs]. (TOML service user 11)

Just one respondent, who would have appreciated the possibility of early evening appointments, voiced a contrasting impression of availability:

> … she says, at whatever time it was, 5 o'clock, "That phone gets turned off" and she said, "Because the nature of some of the people I deal with, some of them can feel suicidal, so they'll be ringing me at all sorts of times" and the inference being that's not her remit, it's not where she goes, which I can understand. She'd have to be a completely different type of person, operate in a completely different way. However, it does seem to me, I knew a guy I worked with, … and he was an outreach worker, and they don't knock off at 5 o'clock. (TOML service user 12)

The contrasting experiences documented here suggest that the availability of TOML staff outside of 'office hours' may be an individual decision on the part of the member of staff.

4.4 Findings: family members' perspectives

Findings from the family member data collection was limited for this research question, probably because participants had limited experience of the service outside of TOML itself. However, they did give their view on TOMl being an age specific service.

4.4.1 Views on an age specific service for the over 50s

Some respondents simply didn't know it was an age specific service. One participant felt that an older person's service was the right thing to do on the basis of differing attitudes to life and relationships between generations, but the majority seemed to favour reducing the minimum age for the service. One participant stated that drinking problems were more related to life events, rather than age in itself:

> I didn't realise that Time of My Life is for over 50 and I wasn't aware of that and I said because it's all about changes in your life. I mean, as you say, you could be in your 20's and you could have an emotional upset which could send you to drink. You could be in your 50's and be made redundant and find it impossible to find a job. You could get divorces. I don't think age is really a factor here. (Family member focus group participant)

However, the overall sentiment seemed to be that they had confidence in the approach of the TOML service and wanted to see it being available to other age groups:

> I think it should be reduced to 30 plus and not 50 plus, because I think that's where the more serious areas start to come into play. (Family member focus group participant)

> I could understand why you would have a niche so you can specialise in over 50's, you know, certain problems that you'd have later in life, but from our perspective, my brother's under 50, he can't use the service. I think highly of the service, obviously. (Family member focus group participant)

4.5 Discussion

This chapter has explored how the Time of My Life model differs from practice as usual within mainstream substance use services. While clearly some variation exists between different service providers, in general, models of practice in substance use services have been highly individualised and single issue focussed. 'Talking therapies' predominate, such as cognitive behavioural interventions and motivational techniques. The aim of these types of intervention is to support the person in their pre- or self-defined goal to change their problematic substance use. This is done in a meeting room in a community-based building. While a service-based comprehensive assessment may enquire, for example, about someone's health, housing status, family, social relationships, and financial stability, staff do not engage with these aspects of their lives beyond advice about, or referral to, other services. Thus, the focus is on the person's use of alcohol or other drug consumption alone. Furthermore, the methods used are seen to be appropriate to, and adaptable for, everyone

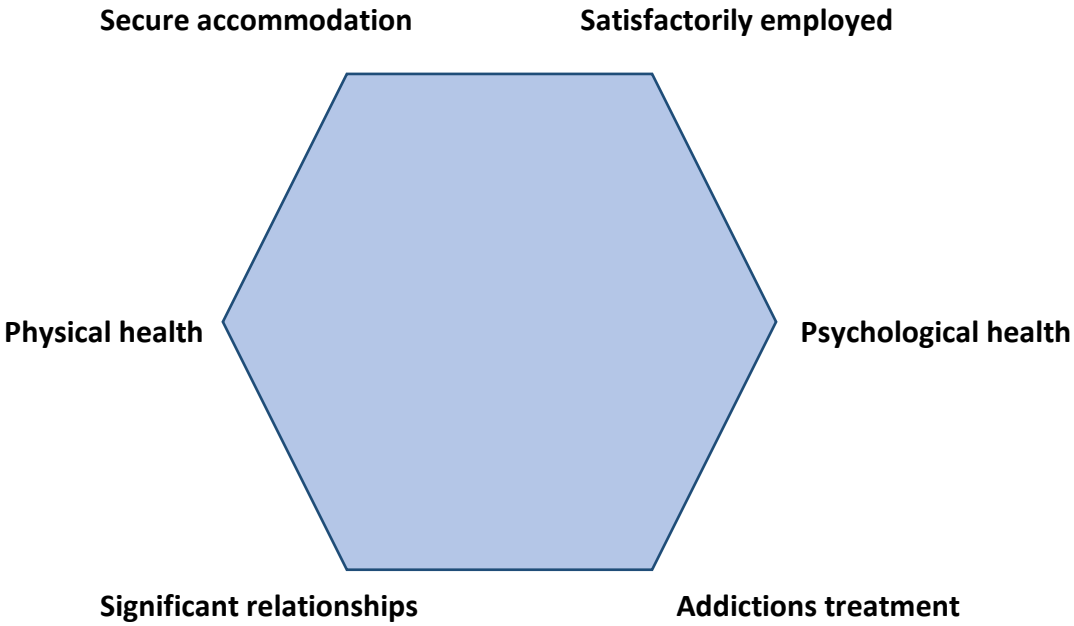
regardless of age or ability.

What differs about TOML is that the core of the project is built on the premise that older people have different, or additional, needs from the general population of adult service users. Evidence shows that a range of life events can place older people at risk of problematic use that do not usually affect younger age groups. These include a number of losses including loss of employment (retirement), loss of partners or family members (bereavement), loss of daily structure (boredom), loss of personal confidence, and an increase in health concerns (physical and/or mental). The TOML model recognises the complex and multiple needs of some older people, particularly in relation to social isolation, and appears to offer practical and emotional support with other needs; indeed, the alcohol work may not always be a priority and this is a departure from practice as usual.

Within the wider context of a rapidly ageing demographic, increasing policy attention has been paid to older people. National guidance on supporting older people with "long-term conditions" and social care needs identifies, assessment, care planning, continuity of care, partnership work and maximising self-management as the key areas in which the health and social care workforce should support people (NICE 2015). What the TOML model appears to do is pay attention to all these areas from the perspective of a substance use service. For many TOML service users, their alcohol use is a long term condition and therefore needs a flexible and continuous level of care that a mainstream service with targets of 6 or 12 week successful completion does not afford. In the TOML model, the staff appear to be adopting an assessment and care coordination role that traditionally may have been the remit of social care services. The staff liaise with many community partners in hospital and other health and social care services and seek to encourage isolated service users to engage with activities to overcome their social isolation. TOML staff are clear that by supporting people in the other areas of their lives, a trusting therapeutic relationship is developed and the wider stresses that support risky drinking can be minimised.

Previous theoretical models have identified this more holistic approach as essential to supporting people seeking to change their substance use. McCarthy and Galvani (2004) developed the SCARS model, the Six Cornered Addiction Rescue System, on evidence that the outcomes of substance use treatment are improved when attention is paid to other aspects of people's lives, such as housing, employment (not just paid work but something to do with their time), and significant relationships. The SCARS model used the analogy of a safety net held in six corners. One corner was 'addiction' or substance use treatment but the remaining, equally essentially corners of the safety net, also needed to be held in order for the safety net to have maximum chance of working. Figure 4.3 below illustrates the SCARS model:

Figure 4.3: SCARS (the Six Cornered Addiction Rescue System)



The TOML model has identified and responded to this range of needs; it addresses each of these areas as part of its service offer.

As noted above, service users also appreciated the practical help, home visiting and flexibility the TOML service offered. However, they were split in their view that separate services were needed for people over the age of 50. While some enjoyed the commonality the older age group brought, others felt it should be available to all. This split opinion may be due to the fact that some people had previously enjoyed a service with a mixed age range of people, and/or that they were not aware of how the service they received differed from practice as usual. Views that the service should be available to all ages stemmed from people who were satisfied with the service they received.

4.6 Summary and recommendations

The TOML model is clearly different from 'practice as usual'. Its flexibility and responsiveness is seen as essential by staff for working with older people and appreciated by service users. However, in the current financial climate of austerity and stringent budget cuts, what will be important is whether a) there is evidence of improved drinking outcomes using this model, and b) whether it is cost effective.

Recommendations

1. Disseminate the model, the learning from it, and its development as an alternative model to engaging and working with older people with alcohol problems and co-existing needs.
2. Consideration could be given to developing a toolkit on setting up a service for older people with drink problems.

Chapter 5 – Volunteer and peer support service

Key messages

- Volunteer and peer supporters allow TOML project to have a wider reach and offer a breadth of support it otherwise could not offer.
- Volunteers and peer supporters offered life experience to service users in a way that many professionals could not or would not feel able to disclose.
- Volunteers and peer supporters were highly valued by their TOML colleagues and this was conveyed to them and felt by them.
- Volunteers and peer supporters were able to develop their own skills and confidence while providing a support for both service users and TOML colleagues.

5.1 Introduction

The volunteer and peer support service is a core element of the TOML model. As outlined in section 2.5, a substantial body of volunteers and peer supporters enable the TOML project to reach far wider than its resources would otherwise allow. This chapter begins by presenting peer supporters' and volunteers' views about their work within TOML before discussing how professionals perceive and experience this component of the project.

5.2 Findings: volunteers' and peer supporters' perspectives

As part of the evaluation, 27 TOML volunteers and peer supporters were invited to attend a focus group to discuss their work and experience with the TOML project. Seven people attended, all aged 50 or over. Much of the data described their involvement in the project and becoming a volunteer or peer supporters and fell into five key areas:

Figure 5.1 – Key themes: Volunteers' and peer supporters' perspectives

5.2.1 Reasons for volunteering

Although participants' reasons for wanting to volunteer were not a focus of the evaluation, three spoke of wanting to give something back, including two who had used the service and one who had not:

> … so for a great deal of us it's just been a natural kind of progression, we've

been enlightened with our feelings and stuff, I think now of course we feel an obligation of "what will I do because I've been helped?" and I've taken from society for so long and I've hurt so many people in various ways that for me now, it's important for me to give back, it's important for people to be able to trust me again and now, … (Volunteers and peer supporters Focus Group Participant)

… it was an advertisement in the local paper and at the time, I was looking to give back into society, my time and I've seen so many lonely people and so many people that just needed support and that's where I was coming from and I made enquiries and then I attended four training days, two weekends and they were excellent… . (Volunteer and Peer Supporter Focus Group Participant)

Another spoke of it as a development from connections with Aquarius as a carer:

But then I come from another angle again as I come from the family side of things, I'm the one who's at home with a son with the addiction and I went to Aquarius for support on that and ended up staying … (Volunteer and Peer Supporter Focus Group Participant)

5.2.2 Roles of volunteers and peer supporters

Most participants spoke of being involved in home visits to clients, accompanying a practitioner, support worker or another volunteer. For some, this was a new learning experience, and a more experienced volunteer spoke of how the volunteer's and practitioner's presence were complementary:

[A] practitioner goes into a person's home as a professional but then I'm sitting there so I start talking more normal and there, you can get the relationship going and we're finding that really works well … both of us working together is actually providing a better service for the person that's looking for the service. (Volunteer and Peer Supporter Focus Group Participant, 129-136)

Participants were also involved in facilitating groups including the TOML breakfast and music group.

Supporting service users to develop and rediscover skills with associated growth in confidence and wellbeing was identified as important in their work with people in the social integration groups whether people were ready for community work or for taking the first steps:

It's great to see those people either who for years and years, haven't felt an important part … for them to come out and then to get themselves involved … it's fantastic because it's given them a new purpose, it's given them a sense of pride, a sense of wellbeing and just for that to happen there, it's like giving them a new start in life which is fantastic. (Volunteer

and Peer Supporter Focus Group Participant)

> … if they want to go somewhere or do something, we would accompany them too because when they'd been through a programme, they can lose confidence in themselves and what might be just everyday thing for each one of us, for them it's major … . (Volunteer and Peer Supporter Focus Group Participant)

5.2.3 Using life experience in being a volunteer

Many references were made to bringing personal life experience to their work as volunteers, both experience of problems with drinking and other life experience. Those with experience of using alcohol services spoke of how once clients are aware of the volunteer's history, they are more likely to 'open up' in the activity groups and encourage clients to talk more about themselves:

> But they do tend to always ask me, I don't know if it's been asked amongst anybody else, "have you worn the t-shirt?", … and my answer is yes and I'll share my story with them and that makes them more confident to come back and to open up about their life and stuff. (Volunteer and Peer Supporter Focus Group Participant)

> From the service users I've met, because they know I'm an ex-service user myself, I've found that the level of trust that they give comes very quickly and I've met people for one occasion, like the first time, and within half an hour, they're telling me all of the stuff, very personal stuff (Volunteer and Peer Supporter Focus Group Participant)

They noted that this approach distinguished them from 'professionals' who were unlikely to reveal their own backgrounds even though they may also have similar histories. However, one participant explained that they exercised discretion about when and how much to reveal about personal experience:

> … everybody has got their own journey but it's how much of that is revealed, I think is up to the person they're speaking to, is up to the environment and the situation there and I'm quite easy to talk away about anything in my life, … but obviously I would tailor that to the person who I'm speaking to, I would be listening to them and what they say to me first of all ... (Volunteer and Peer Supporter Focus Group Participant)

Another factor identified in this sharing of experience was being an inspiration to service users through the progress that the volunteer had made:

> And it inspires people, it gives them confidence in the fact that … because you've been through it and you've achieved certain goals and milestones, that gives people then the opportunity to think, "I can do that as well"… (Volunteer and Peer Supporter Focus Group Participant)

5.2.4 Developing volunteers' and peer mentors' skills and confidence

Bearing in mind that a majority of the volunteers had, themselves, been Aquarius/TOML clients, some saw the experience of becoming peer supporters and volunteers as part of a continuing progression in developing skills, confidence, and self-worth:

> As peer support, we've learned to not be too afraid of change, to be able to be a lot more flexible with things going on and that is a reflection on ourselves as well because I'm now more flexible and adaptable but the thing I've discovered about myself is the mental strength which I've acquired over the past four years, I think that's the biggest thing for me… (Volunteer and Peer Supporter Focus Group Participant)

When asked about the training and support they were given, one respondent spoke of a "Massive amount of training and support from them" and a willingness by the volunteer coordinators to run training they request. They had also received more formal training opportunities around topics such as mentoring, which focus group participants saw as being highly rated by Aquarius management and the external assessor:

> The external assessor came in and she was just blown away, she said, "this work is absolutely first class"… (Volunteer and Peer Supporter Focus Group Participant)

One respondent spoke of the challenges of re-orientating herself towards education with preconceptions of her ability but realising eventually that she was capable of doing it. Another referred to their varied backgrounds and the mutual support in the group as they completed the training:

> … we support each other so whoever has got a certain strength will help out a person who hasn't got that strength there and that goes right through everything we do. (Volunteer and Peer Supporter Focus Group Participant)

5.2.5 Relationships with the service – being listened to, feeling valued

Volunteers spoke highly of feeling valued by the service and being listened to, with much of their input being acted on:

> *Participant 1*: I think that's the good thing about here, the professionals here allow the volunteers to actually have an impact on the service, they really do value, that's the difference for some other charities, they organise it and you just do whatever, I think the difference is that-
> *Participant 2*: We're not here to just do as we're told, we're here to put input into Aquarius and if we feel we've got something that we've come across that would be useful, then we say it and they take it on board. (Volunteer and Peer Supporter Focus Group Participant)

Opportunities to represent Aquarius and TOML were mentioned, both as evidence of being

valued as “ambassadors” for Aquarius and as part of the volunteers’ continuing development. This instilled a sense that they were trusted by staff which in turn increased their self-confidence.

> … giving us trust, giving us responsibility there and having the confidence in us being able to deliver the things, even though it’s still scary and daunting but now we are quite confident enough to be able to go down [to London] … (Volunteer and Peer Supporter Focus Group Participant)

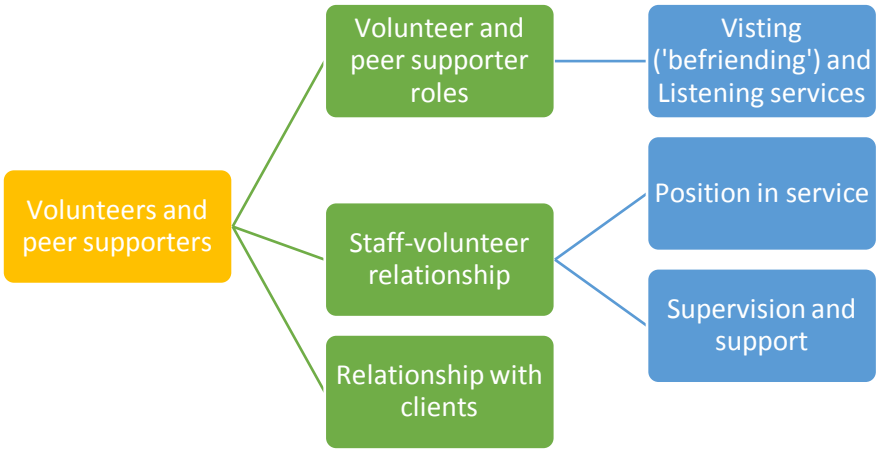
> For me personally, to feel that you can go and sit in on the trustees’ meetings, I think that’s massive because I would have said that would have been a bit of a closed shop but no, it’s not, they want us there and they want to listen to what you’ve got to say, what your opinions are on different things. It’s vitally important. (Volunteer and Peer Supporter Focus Group Participant)

This group of volunteers and peer supporters were positive about their experience as part of Aquarius and the TOML team. They were, however, a self-selecting group of people and only a small group from within the wider volunteer and peer support group working with TOML staff and service users. However, their feedback suggests that both TOML and Aquarius are doing well in their inclusion of volunteers and their support and encouragement of them as a key part of the TOML service delivery.

5.3 Findings: professionals’ perspectives

The professionals identified the volunteers and peer supporters as a fundamental part of the TOML service. In the time one interviews with professionals, three key themes emerged in relation to their work (see Figure 5.2 below), i) reflections on volunteers and peer supporters’ roles, ii) Relationship with clients, iii) Staff-volunteer relationship.

Figure 5.2 – Volunteer and Peer Support themes: Professionals’ perspectives



5.3.1 Volunteers and peer supporters' roles

In describing the volunteers and peer supporters, professionals described them as motivated, enthusiastic, skilled and having a range of experience that supplemented or complimented their own. They were generally an older group of volunteers compared to other Aquarius volunteers including the largest cohort of Aquarius volunteers and peer supporters over the age of 60.

At time 1 interviews, the professionals reported people as being very involved in group work with some running or facilitating the groups without the professionals being present. Some were attending home visits with practitioners and support workers and others were beginning to work with the new listening and visiting[7] services. Their roles also included supporting the organisation of events and trips, writing a newsletter and offering service users support with practical issues other than alcohol interventions where they had the skills and knowledge to do so.

While some volunteers and peer supporters had started to go on home visits with some practitioners or support workers, this was not a blanket policy and staff stated it would depend on the skills, knowledge and capacity of the individual volunteer or peer supporter. Generally speaking, volunteers supported people who were deemed 'low risk' and more stable in terms of their alcohol use.

Many staff spoke of volunteers and peer supporters as providing them with an opportunity to do so much more than they would be able to otherwise:

> I think it gives us like a massive scope to do things that with the amount of staff on the team compared to just the amount of potential clients in Birmingham, I guess we wouldn't really be able to deliver half the service without them, so the majority of the activity groups are run by volunteers, additional support for older people doing a 12 week treatment programme isn't perhaps long enough so having somebody to check in each week or meet them as a kind of continued support, is vital really in terms of relapse prevention. So that work, I don't think we could do in terms of staffing that … (TOML staff member 8)

This additional support was clearly allowing TOML to deliver services beyond its paid workforce capacity while providing a more supportive and consistent service to people when the more intensive work was completed or not available.

Staff also reported that volunteers and peer supporters offered people a different view or perspective and one that was often based on experience. At times staff reported this had facilitated a person's engagement with the service as they could physically see someone who had accessed the TOML service and come out the other side.

[7] The visiting service was often referred to as the 'befriending' service by staff.

Visiting and Listening Services

At the start of this evaluation these two services had just started to be established. The Listening service is a telephone support service staffed by volunteers from the TOML offices in the North and South of the City.

> With regards to the listening service which is now up and running, that's for clients who have stabilised. They're not under risk, it's just giving them a call, I believe, every other week or once a month, just to see how they're going. It's just a check-in to see how … because with the over 50's we know there's a lot of isolation, it's a good service which they can have the option of opting out of it if they wanted. Just someone saying, "How's things? How are you? What's new?" That sort of thing. (TOML staff member 2)

The Visiting Service is a home visiting service which offers informal companionship and extra support for people who have valued the contact their time with TOML has given them.

> I always think the volunteer listeners and the volunteer visitors, it is almost like a befriending service because they're not actually giving them any support with their alcohol use, what they're doing is helping them to build structure for their life and have more confidence. (TOML staff member 3)

> I've got a man who hasn't had a drink for months now and he's doing really, really, well but he just likes the visits because he likes someone to talk to so what they're doing is ... unfortunately he's got problems and he can't speak over the phone but because we're now setting up the befriending service which is when they actually do the visit, a volunteer will come and take over that from me basically. (TOML staff member 6)

For these services, professionals reported having volunteers accompany them on their last few sessions to introduce them to the service user before continuing to visit or talk to that person without them.

Staff reported a number of safeguards in place to support the volunteers and peer supporters in these roles and these are discussed further below.

5.3.2 Staff-volunteer relationship

From the professionals' perspectives volunteers and peer supporters were viewed very positively by the team. They were viewed as potential future staff and integrated into the team. This included the provision of training for professionals on how to support the volunteers and peer supporters and also training for the volunteers and peer supporters for their roles alongside the team as well as independently of them.

Initially staff reported not understanding the volunteers and peer supporters' role in the TOML project nor how to access them but this appeared to have changed:

> It was something that I didn't really get involved with much at first, not because I didn't want to but because I just didn't have time, but I've got a lot better understanding of what the peer supporters and the volunteers and the listeners are doing. But I think that's the biggest change because they've fought for that. They've proven their worth and it's been the best thing that we could've done because they have been fantastic. (TOML staff member 4)

> …they're using volunteers more than they did, they were a bit slow getting to grips with using volunteers, I think that has improved dramatically, it's probably just a process that lots of new projects go through, just reminding them of the initial objectives and making sure that they work with them. (TOML staff member 1)

Staff reported good communication between volunteers and peer supporters and professionals in relation to their work even when there was no frequent contact:

> Although we don't have day to day contact with the volunteer listeners, if they're doing our groups or if they're coming with us on one to ones or there's an emergency situation, we will network with each other and then pass information between each other and support the client in that way as well. (TOML staff member 5)

Other examples were given of ensuring the volunteers for the Listening service had access to staff in case someone on the phone was particularly distressed and staff could either advise the volunteer or continue the phone conversation instead.

Supervision and support

Volunteers and peer supporters were offered supervision and support in a number of ways including formally through group supervision with Aquarius volunteer and peer support coordinators and through contact with the project team.

Volunteers also completed debrief forms for groups they facilitated and staff provided phone support and supervision after the group to ensure they had the opportunity to discuss any issues that may have come up in the group and to offer support to them as facilitator.

Individually volunteers and peer supporters had discussions with staff about their developmental needs and/or how things were working out in their roles. However, one staff member identified the need to improve feedback to volunteers and peer supporters on their work, even those who were doing very well:

> As an example, we had a lady who volunteers for us who does some fantastic stuff and because we have had other volunteers that we've had times that we had a chat to and give feedback to, this lady was always doing fantastically, we kind of forgot to feed that back and I remember her speaking to us one day and saying, "Am I doing all right because I'm not

> sure?" and it was like "yeah, you're doing fantastically" but because we hadn't given her that feedback, she was questioning herself and good feedback is as important as giving somebody some guidance. (TOML staff member 8)

Training was also provided to support the learning needs of volunteers and the focus of training was responsive to requests from the volunteer group. Extending this to the peer support group was being considered. Accredited mentoring training (OCN Level 3) had been provided for volunteers from the TOML project and had received excellent feedback from the external examiner.

Position in service

The volunteers and peer supporters were undoubtedly valued by staff and their perspectives reported in 5.1 (above) seem to reflect that. One staff member, who said they were 'inspiring' to service users, was keen to learn from them:

> When we do the groups, I normally work with a peer mentor or volunteer as well so they learn off us and we learn off them and I don't know whether it's done across the board but after the session, be that a group or one to one session, I normally check in with the volunteer or peer support afterwards because it's like a 360 learning curve for me, what did they get out of the session, what did they learn, did I miss anything because they might have been there and got the t-shirt? And what can I learn off them and what can they learn off me and how they felt it went in general? (TOML staff member 5)

The volunteer and peer support work was also viewed as a sustainable element of TOML even if funding to continue the project was not found:

> I think the volunteer programme could be sustainable, even if we aren't granted any further funding, I think the learning and the practice that's been put in place which is age specific, the volunteer programme, would be sustainable throughout Aquarius because I think that's something that work with the volunteers, that [we] can be taking forward, the learning can be used and developed upon. (TOML staff member 3)

Importantly, staff reported celebrating their volunteers and peer supporters' contribution with events to thank them for their time and providing training to meet their needs.

5.3.3 Relationship with clients

The presence of volunteers and peer supporters was seen as reassuring for clients. One practitioner spoke of having a volunteer and peer supporter accompany an assessment visit:

> …having them there initially breaks the barriers down sometimes between worker and client because they can say, "I'm a peer mentor, I've been where you are, this is how Aquarius can help, this is what Aquarius can

> offer" and then it puts them at ease and then I continue with my assessment. (TOML staff member 5)

Another spoke of the credibility the volunteer added to the intervention due to his life experience:

> I've got a client who's been drinking for 30 years and was adamant he could not stop so I brought a certain volunteer who hasn't had a drink now for four years but drank for over 40 years and the client could not believe it, because he said, "People tell me I've got to do it but I've never seen anyone do it." It goes to show that the volunteers do a hell of a lot and really encourage the clients. (TOML staff member 12)

Volunteers were also seen to add warmth and credibility to the engagement process:

> I'm not saying that I'm inadequate but sometimes when somebody's talking to somebody about a life experience and we're talking from a text book or a training … we're not going to, maybe, have the same, what can I say…engagement, as somebody who's talking from experience of hitting rock bottom and saying, "Look, today, look where I am today." A lot of people will feel more warmth towards them because this person is in front of them, it's real. (TOML staff member 2)

Volunteers also provided a consistency of contact for the clients given the scarce resources of paid staff covering a large city. They were seen as being able to develop an ongoing helping relationship because they had the capacity to do.

One member of staff raised concerns about ensuring volunteers and peer supporters understood limits to their roles and issues of confidentiality and boundaries:

> I think again, it's really important for both volunteers and peer supporters [to know] about boundaries, who they give phone numbers to and it's really reiterating the importance of boundaries etc. (TOML staff member 3)

While relating to the service user was identified as bringing a particularly helpful perspective at times, staff were also aware that peer supporters could over identify and, for their own continued health and well-being, may need to be able to debrief.

> … sometimes if [the peer supporter has] made a particular friend of a client or if they feel particularly [that] their story runs parallel to this other client, sometimes the overwhelming urge is to help, no matter what. But sometimes the boundaries can be blurred and obviously that's why we are here to support them to make the right decisions about those boundaries and reinforce them, it's protecting both the client and the peer supporter. (TOML staff member 3)

5.5 Discussion

Volunteering in the UK has been brought to the fore in recent years due to the serious cuts to health and social care budgets. However, the predicted rise in volunteering has not emerged. Data from the Institute of Volunteering Research (IVR) (2016) show that volunteer rates are relatively stable and have been for some years with 27% of people, on average, undertaking formal volunteering. The reasons the IVR gives for people not volunteering are:

- 60% of respondents cited work commitments
- 34% simply did other things with spare time
- 31% stated they looked after the home or children
- 14% said they were studying
- 14% said they did not know of any opportunities to help
- 12% said they did not know of any groups needing help.

In the only survey to date of formal volunteering by local authority area (Department of Communities and Local Government 2009), 21.7% of people in the West Midlands region had given help at least once per month. In Birmingham City Council's area, this number fell to 16.7%.

TOML currently has 27 volunteers and peer supporters of which seven attended the evaluation focus group and this is a limitation of our data. An additional 15 volunteers were not actively employed with TOML at the time which presents the reality of a fluctuating volunteer workforce. However, there was a clear message that participants in this evaluation felt valued by Aquarius and the TOML project and this was reflected in the comments of the paid staff throughout the evaluation.

The volunteer and peer supporter role appeared to develop and change over the course of the evaluation period. Given this was a new service there are a number of practical and operational reasons for this:

a) Paid staff became more familiar with, and understood, a new model of working which included working alongside volunteers.
b) Increased recognition among paid staff of the value of volunteers and peer supporters.
c) Relationships between staff and volunteers and peer supporters are built over time; staff would develop a growing awareness of individual volunteer's and peer supporter's skills and potential.
d) Paid staff capacity did not increase in line with demand for TOML service and therefore the inclusion of other roles for volunteers and peer supporters were necessary to provide some service to people.
e) New services were rolled out within the organisation which were staffed by volunteers and peer supporters, i.e. the Visiting and Listening Services.

In the current economic climate, it is expedient to maximise volunteer and peer supporter contributions while offering opportunities for skill development, potential employment and employment experience. Mountain et al. (2015: 5) recommend the use of volunteers "to

extend and improve service quality rather than the means of reducing service costs" and refer to the "fragility" of the arrangement with volunteers as needing ongoing attention to retain their support and volunteer service provision.

For volunteers and peer supporters who have come from a background of problematic substance use themselves, evidence shows that employment opportunities can be difficult to find (Bauld et al. 2010). Volunteering within a substance use service presents an ideal way to develop skills and build work experience to support future employment chances. However, robust systems of selection, screening, training and support for the volunteer and peer support team need to be in place to safeguard themselves, paid staff and service users.

While this was apparent within Aquarius, it will need to be maintained. Mountain et al. (2015) highlight the challenges of retention of the volunteer workforce and the reliance on them for continuity of interventions. Their study describes the development and cessation of a telephone support service for older people run by volunteers and highlights the need to maximise retention of volunteers through 'buy in' to the interventions in which the volunteers would be involved from the outset. They refer to the 'contract' with volunteers as "a fragile arrangement" and state that "the volunteer workforce cannot be expected to perform in the same manner as paid employees" (p. 5). Within the TOML project, volunteers in particular, had clearly taken on the support worker facilitation role for some elements of the service and their roles were expanding.

The visiting and listening services also appeared to be wholly reliant on volunteers and peer supporters for their operation. While paid staff were in the vicinity to offer support as need arose, it was clear that they would not have the capacity to add these services to their workload if the volunteers were not available. This adds an element of risk to the continuity of these services if volunteer rates were to fall. According to the year two (2015-2016) figures for the TOML project, the volunteer recruitment target had not been met. However, some reassurance may be that formal volunteer rates in England have been relatively stable in recent years with with only small fluctuations (Institute for Volunteering Research 2016). In order to continue this service to TOML service users, there is pressure on Aquarius volunteer coordinators to constantly shore up the number of volunteers and to train, support and supervise this volunteer group. The volunteer coordinator role remains a vital resource.

Both professional and volunteer and peer supporter staff identified the life experience of people with prior substance problems as being a positive thing for service users. Among this group there was no reflection that it could also have a negative influence on people, potentially reinforcing failure if volunteers and peer supporters were to adopt the 'if I can do it you can' approach. Similarly, there needs to be safeguards against the influence of evangelism of particular approaches which became evident in one service user interview when someone said Aquarius' approach of not requiring abstinence was used by people as an excuse to drink. The importance therefore of training, supervision, and joint working with professionally trained staff remains key to positive involvement of volunteers and peer supporters.

This is an area in which further research would be beneficial to establish the effectiveness of

interventions delivered by volunteers and peer supporters and the challenges both they and TOML/Aquarius face in retaining continuity and service standards.

5.6 Summary and recommendations

The volunteer and peer support service within TOML remains a vital resource for the project and the delivery of some services. The staff TOML clearly recognised their value although for some this recognition had taken a little time to develop. The volunteers and peer supporters also felt supported and valued and were positive about the training they received and the responsiveness of the organisation to their training needs.

However, the sustainability of the volunteer and peer supporter team and the services they support, or provide, will continue to rely on the investment in retaining and recruiting a body of volunteers to the project. This has implications for the ongoing resourcing of the volunteer coordinator roles.

Recommendations

1. Continue to commit resources to recruiting, training and retaining TOML volunteers and peer supporters in order to sustain their contribution to the TOML model.
2. The OCN course and its success should be highlighted and disseminated as good practice.
3. Given people's willingness to discuss their own experiences and journeys through services to volunteer and peer supporter involvement, consider developing short audio-visual clips drawing on these experiences as a recruitment and promotion tool. This should include people without personal substance use histories experience too.
4. Consider carefully the range of tasks volunteers and peer supporters are involved in and the ongoing supervision, monitoring and development needs to support and retain them.
5. Ensure there are clear channels of communication between TOML staff and volunteers and peer supporters to maximise feedback and to help new volunteers and peer supporters to embed into the team as quickly as possible.

Chapter 6 - Individual work

Key messages

- The TOML model allows for the development of closer and more developed therapeutic relationships between users of the service and professionals.
- TOML service users report feeling supported not patronised and given confidence and encouragement to take control of their drinking.
- TOML service users also report a range of benefits in reducing or stopping their drinking including improved physical and mental health, improved relationships with family and friends, and greater preparation for work.
- Drink diaries were among the tools identified as helping people to change their drinking behaviour.
- TOML service users felt strongly that ongoing support would be available to them from TOML or Aquarius should they need it.

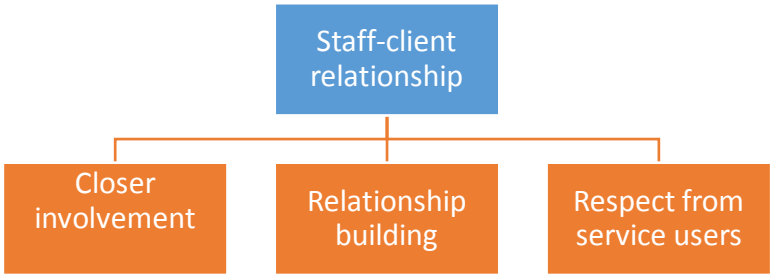
6.1 Introduction

Individual work between TOML staff and service users forms the core work of the project. As identified in chapters 2 and 4, much of this work is conducted in people's homes or in the two TOML office bases in the North and South quadrants of Birmingham. However, it is also conducted in hospital settings and, where feasible, in the community settings where groups are held if people request 1-1 support during their group attendance.

6.2 Findings: professionals' perspectives

Figure 6.1 below identifies the key themes which were identified by professionals in relation to the individual work.

Figure 6.1– Professionals' views on the staff-client relationship



6.2.1 Staff-client relationship

Staff identified the relationship with TOML service users as different in nature to their staff-client relationship in other Aquarius services. There were a number of aspects to this: closer involvement with people, longer time spent relationship building, and a perception of greater respect from TOML service users than from mainstream service users.

Closer involvement

Professionals reported a much closer relationship with people using the TOML service than was found in mainstream services and how professionals had to remain aware of the limits and boundaries of their care:

> I think the staff are just much more immersed in someone's life than they are in the broader treatment service, is the main thing; it's impossible not to get pulled into other aspects (TOML staff member 11)

> … you have to maintain that professional boundary, while not standing on it if you like, but it is important because you're not going to in their lives forever, the idea is to get them to build their own community of friends and their own social contacts. (TOML staff member 10)

Relationship-building

Part of this professional closeness appeared to come from listening to older people's stories of their lives, what they had experienced or endured, and from taking the time needed to build relationships that would allow this level of openness:

> But if you think about a lot of people brought up with that type of stoicism might find it quite difficult to sit down with somebody and talk about what their issues are, so it's about professional relationship building. So if you're working on a six week model, sometimes you'd only have just got to know somebody and they'd have started letting their guard down and talking to you, by the time six weeks has come around, so the fact that we haven't got a definitely timescale to work with somebody, is really helpful. (TOML staff member 3)

Clearly staff also recognised the need to form a relationship first and then introduce the alcohol element, particularly with some communities:

> With the Asian and black community, you've got to build their trust. For them to start talking to you about alcohol or anything, they've got to work you out first, that's how it works with them. Once they're comfortable enough then they want to talk about whatever they need to talk to you about. (TOML staff member 2)

The importance of building trust and relationships with people was highlighted by staff repeatedly, including the need to treat people as adults not children and to talk 'straight' to people. Some staff criticised other agencies for not focussing on the person and just treating the alcohol instead. Staff provided examples of people who had been resistant to engagement with the service but who participated once the staff-client relationship was established.

> So you have, you've got to build that relationship up with the client first and you've got to see where they are as well. I had a client a few weeks ago … She was just curled up like a little baby. By the time we left she was laughing, joking. … [the TOML volunteer] was making her laugh and we went to see her two days

> ago and she's so different… those first few meetings are crucial -you've got to make that connection. (TOML staff focus group member)

Respect from service users

Staff who had been working in mainstream services prior to the TOML project reported this older group of service users having a much more respectful attitude towards the TOML service:

> …we've got people that see it as we are giving them a service and they would respect that service. There tends to be a lot more that they respect. This is our time that we're giving them and a lot more respecting…there's that level of 'old school'-ness, do you know what I mean? (TOML staff member 1)

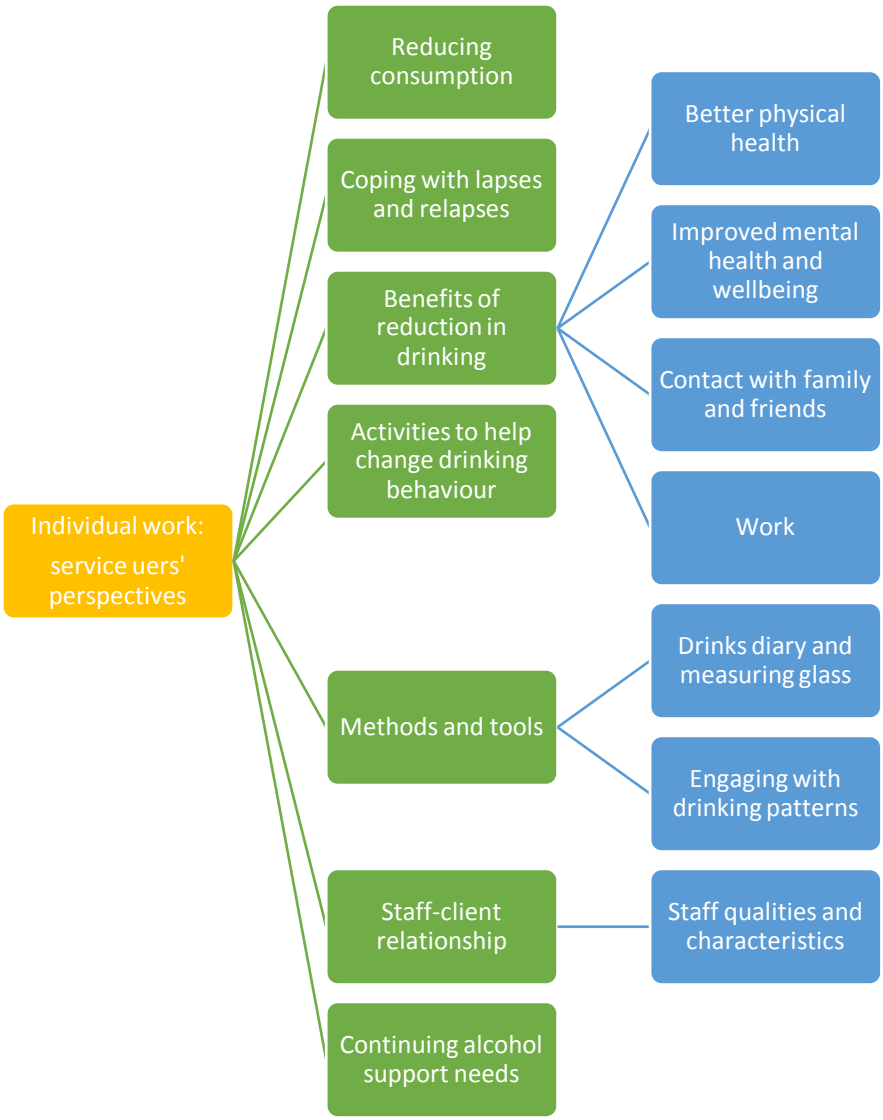
> So the older generation are a lot more respect[ful]and don't feel like they're owed stuff. (TOML staff member 6)

It was clear from the interviews with staff that there was a closer relationship with this group of service users in general than with other mainstream service users and this tallies with the high levels of gratitude many service users expressed about the TOML service they'd received. This undoubtedly relates to staff becoming familiar with a range of areas in the person's life including visiting their home, family, understanding their health and well-being needs and acting as a facilitator at times to ensure their wider needs were met. Staff appeared to enjoy this wider role although it also raised challenges for individual staff and the team generally.

6.3 Findings: service users' perspectives

The 1-1 work with TOML staff appeared to be fundamental service users' efforts to change their drinking behaviours. The following themes were identified relating to the work with TOML staff (see Figure 6.2 below):

Figure 6.2: Themes based on service users' perspectives of individual work with TOML staff



One of the aims of the evaluation was to explore service users' experiences of drinking behaviour and drinking lifestyle change as a result of TOML service provision. While some service users reported stopping alcohol use completely, others reduced their consumption and many reported on the benefits from this reduction or cessation.

6.3.1 Reducing consumption

Some participants spoke of being guided to reduce consumption gradually, even though in some cases they doubted that they could do this:

> We then went down from regular drinking smaller and smaller amounts to having alcohol free days, which was a big step. It was a big step as far as I was concerned. I was concerned that I couldn't do it, and in fact I could. I was concerned I couldn't do it for two days or three days, and I did. And I did it faster than it was suggested. I took very much control of myself.

(TOML service user 7)

Others reported success in reducing their consumption to just social drinking:

> I went into a pub and I had two pints and I went home before closing time and I didn't have drink when I got home. Which I feel pleased with myself for being able to do that. (TOML service user 9)

6.3.2 Coping with lapses and relapses

Coping with lapses and relapses featured in participants' accounts of drinking reduction with one person saying that TOML support had helped him acquire the resources to overcome a relapse when services are traditionally closed:

> It's nice, it's like having a bit of a safety belt knowing that there's something that has worked in the past. In fact, having had this type of reaction [relapse] over Christmas when it's a bit difficult to go back, I didn't contact them again. I do feel hopefully that when it occurs again, because it will occur again, that I'll be able to control it and to resume a steady course. (TOML service user 7)

Another person spoke of a relapse and wanting to become more confident in coping with future lapses, including better use of her time:

> So this time I've actually had a relapse ... when I'm confident that I'm not going to, or that I can cope with a lapse… and then get back on track again and stop drinking and feel confident with that ... and also start doing some voluntary work, doing a bit more with my time, then I think I'll be able to go it alone. (TOML service user 10)

Identifying situations where there was danger of relapse was helpful to another person:

> It's like now I do have a drink now and again, but I get an urge for a drink on a Saturday night because I always used to drink on Saturday nights, and Saturday nights are one day that I will not drink because I'm worried in the back of my head that if I have a drink on a Saturday night I won't stop and it'll all have gone to pot, and I'm not doing that. (TOML service user 4)

6.3.3 Benefits of reduction in drinking

Many participants spoke of successes in reducing drinking and other life benefits that went hand in hand with reducing drinking.

Better physical health

Participants spoke about improved physical health once they'd stopped or reduced their drinking:

> And the other thing I've done is had a medical at the doctor's since I've quit and my bloods have all come back fine. My blood pressure's always been fine. Everything's come back tickety-boo. I don't want to destroy that. I think I would have done if I'd carried on. (TOML service user 4)

> Participant: I don't go and see doctors or anything anymore.
> Interviewer: So your health is better?
> Participant: Health, everything, my eating's better, my life is better, everything is generally getting better and better so it's everything is improving. (TOML service user 6)

One person spoke about the direct benefits of reducing consumption such as freedom from physical symptoms of withdrawal and an appreciation of being able to engage in other activities:

> I don't get no shakes, I don't get no cravings. I don't get none of the sweats or palpitations, whereas before, I was literally … well, I wouldn't even leave the house because I was frightened that, "Oh, I can't take my drink with me," but now if Aquarius phoned me up this afternoon and said "… we need you down the garden, there's a tree grown over. Are you alright to come down and give us a hand?" I would [clicks fingers], "Yeah, I'll come down," and it wouldn't bother me. (TOML service user 13)

Improved mental health and wellbeing

Participants reported feeling more positive and happy with themselves as a result of reducing or stopping their drinking:

> Well, I feel a lot more positive. I really feel a lot more positive. I do suffer with depression but my mood has been really uplifted lately, it really has, it's been nice. I'm looking forward to getting out of bed in the morning. (TOML service user 3)

> I just feel better in myself. I used to love walking and I'd virtually stopped going out walking anywhere, and now quite regular on the weekend I'll go with my daughter and we'll walk seven/eight miles across public footpaths and bridleways etc. These are things that I did, and I don't think I'd realised how I'd sort of stopped doing, just over a period of time it faded out and I wasn't doing half the things that I used to love doing. And I'm doing them again now and I'm happy. (TOML service user 4)

Contact with family and friends

Participants spoke about losing contact with friends and families as a result of drinking, and then improvements as they reduced their drinking. With regard to friendships, this might involve curtailing contact with people they had met through drinking and re-establishing relationships with friends they had lost contact with:

> It's easy to get in touch with other alcoholics. … So then your friendship starts growing with them. So the real friends are then by the wayside. So basically you've got to change everything after you've stopped drinking. It's get rid of the ones you've latched onto, picked up on the way, and they've latched onto you as much as and you have to just let them go and get rid of them or whatever is necessary and then get back in touch with the ones who don't drink or it don't affect them, you know, have normal lives for want of a better term but it is more of a normal life. (TOML service user 6)

Another respondent emphasised the peer support element of new friendships made through TOML groups:

> Because we always support each other. We've all got our issues. Some are drugs, some are drinking, some are gambling, some have got debts and we put ourselves all in the same boat. We don't class each other and we discuss each other's problems. I've never heard anybody saying a cross word with each other. Somebody doesn't get upset, "Well you're a junkie," or, "You're an alchy," or "You're a gambler," or "You're in debt to your eyeballs you can't even buy a cup of tea." It's a very friendly atmosphere, it really is. I've got most of their phone numbers, I can phone them up. (TOML service user 13)

Participants reported improved contact with their families as they gained control of their drinking:

> Interviewer: What about your relationships with your family, are they any better now?
> Participant: They're a lot better than they were. A hell of a lot better. I see my grandchildren on a regular basis now. (TOML service user 13)

> Interviewer: Have you seen more of your family since you stopped drinking as well?
> Participant: Oh God, yes.
> Interviewer: That's been good?
> Participant: Yeah and next week, my daughter, because her partner works away a lot so when he works away, I go and stop there for the week and I'm going there Monday to Friday because he's going away. (TOML service user 2)

Work

Some participants spoke of better functioning at work, and of feeling more able to look for paid work:

> I'm a lot more switched on at work. Some days I was going into work and it was just like … But now they're giving me loads of projects to do and

> keeping me busy so I must be doing something right. (TOML service user 11)

> I feel better in myself, I feel more positive in myself. I feel more happier with myself. … That's why I'm looking now for my full time job… . (TOML service user 14)

Other benefits mentioned included being better able to write, sleeping better, some relief from financial problems, and being a nicer person.

6.3.4 Activities to help change drinking behaviour

Participants spoke of finding a variety of activities helpful in relation to controlling and reducing drinking. Some of these arose from respondents' own initiatives but some were initiated or supported by TOML staff:

> [TOML worker] is trying to push me to do more bird watching because he says it gets you out, it takes your mind off any problems, you can get your exercise. … I'm going to pack my gear and take it over to see [TOML worker] and then I'll go bird watching straight after that. (TOML service user 11)

Participants spoke of finding a variety of activities helpful in relation to controlling and reducing drinking. These were a mixture of respondent's own initiatives, organised activities through TOML or other organisations, and those arising from circumstance such as time with friends and family.

TOML workers helped service users understand the value of activities as a distraction from drinking:

> … it [TOML service] makes me a lot more aware of what I was doing, … because now I know what I was doing, I can do things to stop me doing it again. Like I say, if I'm sitting here bored … I can get on my trolley and I can go outside. Even if it's just go to the shop, it takes me out of that moment, it takes me out of that moment that made me think, then I can just come back, then all different. (TOML service user 22)

> Anything that distracts, yeah. That was something that [TOML worker] had suggested, not specifically like walking halfway home or reading a book, but I integrated her ideas with what I thought were good for me. What helps me might not help the next person, I think everybody's a little bit different. (TOML service user 4)

6.3.5 Methods and tools

Another aim of the evaluation was to identify, where possible, the TOML processes that helped people to make changes to their problematic drinking. It includes references to any

processes that seemed unhelpful and barriers to the operation of these processes. Participants referred to specific tools or approaches that TOML workers used in the course of individual work to help them reduce their drinking.

Drinks diary and measuring glass

A number of participants mentioned TOML's use of a drinks diary as useful way of monitoring patterns and consumption:

> Participant: …it must be frustrating when [TOML worker] comes and I've had a really ... Because I keep an Aquarius diary and I can have a week where I've had say four off and three on days and it's all going great. Then maybe a month later ...
> Interviewer: You're back to nearly every day are you?
> Participant: I don't very often go back to every day no, but it can perhaps be the opposite way round, you know four ...
> Interviewer: Four and three good?
> Participant: Yes. (TOML service user 17)

> You have a little diary that you're given … that you fill out on a daily basis giving the time of alcohol, the type of alcohol, the quantity and the alcohol its strength, where you were and who you were with. So it was quite intensive, quite all embracing. That was on a daily basis and then every week you'd pop in [to TOML service] and go through it. … I regularly would go back and actually work on a target which was slightly less than the one that [the TOML worker] was expecting. (TOML service user 7)

As consumption decreased, one respondent moved to using a calendar:

> … I used to do a drinks diary but that was when I was drinking more or less every day but now, [the TOML worker] said to me before Christmas about the diary, he said "Just get a calendar and tick every day you haven't had a drink, a cross on the day you have and just go through it", I've gone through all that … and he says, "that will help you" and that's what I have done, that is my drinks diary. (TOML service user 2)

However, one respondent did express a contrary view that diaries might be used as an excuse for drinking:

> And then subsequently being in AA, being in rehab even, many people have told me like that they use Aquarius as an excuse because of the diaries. Showing the missus or the mother or the husbands or whatever the diaries and saying, "Here we are, look, they told me I can drink, so I'm alright, I've just got to do this diary". So it gives an alcoholic a leeway to just continue drinking. Because they're using that, you guys, as an excuse. (TOML service user 6)

At least three participants referred to finding a plastic measuring glass provided by TOML,

useful in managing consumption as it indicated the number of units per volume for different kinds of alcoholic drinks.

> …it wasn't until I got the plastic beaker and the book and actually measured it, and put it down that I thought… "Blimey! No wonder that bottle don't last long". (TOML service user 22)

Engaging with drinking patterns

Participants spoke of the role of the TOML worker in helping them to engage with their own drinking patterns in trying to reduce drinking, and creating new ones. This might involve recognising triggers or situations associated with drinking:

> Also I remember saying to [the TOML worker] because I was cooking, because I actually really, really like cooking but I associate cooking with having a drink. So at the moment I'm not doing very much cooking and I said to him, "I'm cooking and I'm looking for me drink and it's not there because I'm not drinking." I'm thinking, "Oh god," and that's really when, you know, so he suggested I get some Shloer which is alcohol free wine or something like that. (TOML service user 10)

6.3.6 Staff-client relationship

As with the professionals, the service users identified their relationship with staff important to their engagement and trust in the service.

Staff qualities and characteristics

Participants identified a number of ways in which staff related to them that were helpful in dealing with their drinking problem. Some related to first meeting and early stages of the staff-client relationship. Others were identified as the relationship developed and remained important through what might be a more long-term relationship with the service.

Non-judgemental and not patronising

Service users reported feeling accepted and not judged by staff working with them which enabled a positive relationship to develop:

> They got me better, [TOML worker] came and visited me every week, he was assigned to me in hospital. He came and saw me every week. As soon as I came back, he came to the house, he supported me. He never once judged me, never once. He said the thing is, you've been through such a lot … (TOML service user 14)

> I think they encourage you as well rather than telling you not to drink, some people can be a bit patronising, a bit like talk to you as if you're a child and they're the adult and "you mustn't do it", whereas this is more like encouragement, "it would be better if you don't". (TOML service user 20)

Staff made client feel comfortable and confident
The ability of staff to put people at ease helped them to relax and express themselves:

> Participant: I was nervous the first time, but I knew as soon as I spoke to the first counsellor I saw, I knew I needn't be nervous because they've seen it all before haven't they? So it made me feel comfortable, that's what I liked.
> Interviewer: How did they make you feel comfortable then?
> Participant: Just letting me speak and get it off my chest. If I got a bit upset it wasn't magnified in any way. It was just we'd carry on to the next thing. (TOML service user 17)

> I think some of it is to do with [TOML worker] himself because he's really quite a very friendly bloke. He's about the same age as my oldest son actually. He's just very easy to talk to and I don't feel that ... Because for a while I didn't stop drinking and I never felt under any pressure because I hadn't at first stopped drinking. (TOML service user 10)

> He [TOML worker] gave me back my confidence. He absolutely worked wonders with me. He put everything back into perspective and gave me a future to look forward to, and how to deal with things … he used to come and say, every time I come and see you, you're that bit better. It just made the progress of recovery so much better. … But really, I don't know where I'd have been without him. (TOML service user 14)

Staff are like a friend
A group of comments about more than one member of staff suggested that they became able to view the worker as a friend and felt this was valuable:

> Well [TOML worker] will always stay a friend. I know for a fact that if ever I ring him, even if it's from six months from now and we haven't spoken or whatever and [TOML worker is] busy doing his job like he does. Well I understand all that, but I know for a fact that if I phoned [him] and if he's needed, I know he will be here for me and he'll give me the right advice. I know he will. (TOML service user 8)

> I was saying [TOML worker] is very good and he's, he feels like a friend actually because he knows. … he's the only one that ever says, if I'm going to be here I'll be here and he does. (TOML service user 15)

> Yeah, and because we've built up a friendship, you don't want to let them down. So even when they're not around, I'm thinking oh, what would he think? What would [TOML worker] think about this if he saw this? He wouldn't like that. (TOML service user 1)

6.3.7 Continuing alcohol support needs

Thirteen participants spoke about their continuing needs, and what expectations they had

of these being met by TOML. There appeared to be a general expectation that they would be able to stay with the service for as long as needed. These participants did not appear to see the TOML service as distinctive in this respect, although comments from staff and volunteers in other interviews and focus groups spoke in terms of other services working on the basis of a 12 week period of support.

Some spoke of how much longer they might need to be with TOML or how far on they would need to be to feel confident without the service:

> I think when I've stopped drinking every day without having any relapses and I feel confident enough that I'm not going to have any relapse. (TOML service user 10)

Others foresaw a continuing need for support, and spoke a little more in terms of a hope rather than expectation that this would be forthcoming:

> Do you know it would be wonderful for me to be able to turn round to you and say, " I've cracked it, I've cracked it." But without Aquarius and I hope that they are going to continue with me, and I'm going to carry on whatever, whatever you need me to do. I'm now going to continue on because this disease is a nasty disease. If you're an alcoholic like I am then you need the help. (TOML service user 8)

Others spoke of coming to an agreement that they no longer needed support, sometimes on the understanding that they could get back to TOML if needed:

> I mean it has been made clear to me that should I need the service again that it is available. Not necessarily through [TOML worker] because he said, "If you do come back I can't guarantee it will be me." But I've had experience of having a meeting with one of the other people working there and that worked extremely well … (TOML service user 7)

6.4 Discussion

It was highly evident that for both professionals and service users the therapeutic relationship they established was at the core of their work together. There is a growing body of evidence, summarised by Miller and Moyers (2014), that highlights the importance of relational factors to positive outcomes for alcohol and other drug treatment.

The ability to build a closer relationship with service users, which would be unusual in other alcohol 'treatment' settings, was the loudest message from TOML staff. The TOML model, described in chapters 2 and 4, allowed an approach that took staff into people's lives and homes in a way that would not be normal practice in substance use service delivery. In doing so, an extra dimension was added to the working relationship and staff were able to identify and support people's other needs, for example, housing, health or debt problems. This facilitated a far greater understanding of the complexity of people's lives.

Miller and Moyers (2014), best known for their development of Motivational Interviewing, highlight how research has consistently shown very little difference between different types of intervention. Even large randomised control trials comparing treatment approaches have shown few intervention effects. They argue that what is missing from research of 'EBT' (Evidence Based Treatment) is attention to the relational factors between service user and worker (or therapist in their language).

> Although it has received scant attention in the addictions treatment literature, there is a broader body of research indicating that one of the best indicators of clients' retention and outcome is the particular counselor to whom they happen to be assigned (Miller and Moyers 2014: 5)

While they do not argue that treatment approach is irrelevant, they do argue that it is time to research and consider relational factors and avoid the consideration of them as 'common factors' as they are often not common. They split such factors into four main areas, i) expectancy – the workers' induced expectations of client potential, ii) allegiance - to a particular treatment approach or model, iii) interpersonal skills – empathy in particular, and iv) fidelity – to delivering what may be "complex behavioural interventions" (Miller and Moyers 2014: 6).

Applied to TOML evaluation data there are obvious parallels. While 'expectancy' was not an explicit focus for discussion, what emerged was a passion for supporting people in the best way they can and this was felt by service users. Both staff and service users provided examples of people who had taken very positive steps and who were highly confident that their TOML staff worker would be available if they needed their support. This may be unrealistic, however, given this was in an environment where staffing changes were apparent during the first half of the project. Others, as chapter 5 shows, had progressed to peer supporter and volunteer roles within the organisation. Professionals were clearly convinced of the TOML model and having time with people to allow relationships to develop as well as encourage them to move beyond their 1-1 work to other activities. The service users highlight a range of staff qualities and interpersonal skills which they valued, such as being non-judgemental and helping them feel confident. The evaluation data cannot determine fidelity however, but staff and service users report an intervention that had spanned many dimensions and aspects of their lives, sufficient to be described as complex. Further, as Miller and Moyers (2014) highlight, fidelity alone is insufficient to effect change.

Change in drinking behaviour and the benefits of reduction or cessation were highlighted by service users. Nationally, successful completion is described as when the substance use professional decides the person no longer requires structured treatment (Public Health England 2016b). Operationally, practitioners view this as approximately 12 weeks of contact. It is also variously described as when a person does not re-present to the service for 6 or 12 months post completion although such criteria do not speak to the flexibility in service engagement so valued by TOML service users. Nor does it consider success as people having learned how and when to use the support available when they feel they need it.

No national data are available on treatment completion by age group, but data for the year ending March 2016 show that 62% of people of all ages in treatment for alcohol alone

completed successfully. Arguably, more emphasis is needed on service users' definitions of successful completion, given that they have come forward to seek help.

For the TOML project, data for the same time period (year ending March 2016) (personal communication, 2016) showed that 66 of 93 TOML service users that year had 'successfully completed' with either no use at all or with 'occasional use' of alcohol or other substances – a success rate of approximately 71%[8]. This is significantly higher than the national average.

The TOML data also show massive reductions in unit consumption between baseline and 'latest' recorded units, even among those who did not complete treatment. Among the latter group, examples include the person drinking 700 units of alcohol weekly at baseline (on entering the service) but subsequently reducing this to 280 units at the point the person dropped out of the service. This is still incredibly high given the current weekly guidance is 14 units (DH 2016). Among the 'treatment completed' categories, the highest number of alcohol units at baseline were 280 weekly units falling to none at completion. However, among the 36 former service users classed as 'treatment completed – occasional user (not opiates or crack)', the majority (n=26) were still drinking above recommended limits ranging from 20 to 260 weekly units at the time of treatment completion. Care therefore needs to be taken with the interpretation of completion data.

6.5 Summary and recommendations

Individual work is a key component of the TOML model. What is apparent from the interview data is that the therapeutic relationship between staff and service users is a strong and highly valued part of the intervention. Service users also reported reductions in their drinking as a result of their participation in the TOML project and a range of benefits as a result. The completion data supplied however may lack accuracy and specificity in recording and this could be an area of improvement in future.

Recommendations

1. Review monitoring and recording of client data to ensure reliable analysis of unit consumption pre and post TOML service, for example. Build in a follow up period of up to 6-12 months post discharge to support effectiveness analysis.
2. Continue to support and promote a model of intervention that encompasses a holistic approach and enables close therapeutic relationships.

[8] There are two categories of completion: i) Treatment completed – alcohol free and ii) Treatment completed – occasional use (not opiate or crack)

Chapter 7 – Group activities

Key messages

- Group activities appear to be the most challenging element of the TOML model in terms of maximising attendance and success.
- The successful groups appear highly valued by those who attend due to the peer support, socialisation, skills development and confidence building some groups can offer. They also provided an alternative or distraction from drinking.
- Staff report that some groups have a focus on alcohol whereas others focus on social isolation and have little, if any, alcohol-related content.
- Service users held a range of views about the groups being age specific. Those who were unsure had experienced the loss of peers when adult service provision was lost to Aquarius and service users had to go elsewhere.
- Service users reported the management and facilitation approach of groups was good, balancing encouragement and direction with a relaxed approach.
- Difficulties accessing some groups were highlighted by both service users and volunteer and peer supporters. Transport provision was identified as one way to help people attend as was increased promotion of the group activities by TOML staff to individual clients.

7.1 Introduction

Group activities and the on-going and dynamic development of group activities is one of the main strands of the TOML model. This chapter presents findings from interviews with professionals and interviews and focus groups with service users that relate to TOML's group work.

7.2 Group observation

In order to ensure the evaluation team were familiar with a range of groups in terms of focus but also TOML group processes, a number of observations were conducted by team members. These served to educate the team about the TOML groups, provide a context for the realist evaluation and inform the development of our interview and focus group questions and topic guides.

7.2.1 Observation methodology

A participative observation approach was adopted which enables researchers to gain a more holistic understanding of the situation being studied, thereby increasing the validity of the research. More specifically, it can reveal phenomena that participants may be unaware of or unwilling to discuss in interviews or focus groups (DeWalt and DeWalt, 2002)

An initial selection of groups for observation and focus groups was made from a list provided by the service. The selection sought to achieve a spread of different kinds of activities and a balance between the four quadrants. In particular, to balance groups that were more alcohol focused with those aimed more at social integration. In practice, however, the original plan of which groups to observe had to be amended in light of both practical considerations and advice from TOML group organisers about particular

considerations, such as attendance and staff sickness.

Four observations took place including a breakfast group, an art group, a coffee morning and a 'knit and natter' group. Two groups were based in the North quadrant of Birmingham, one in the South and one in the West. The information given to the evaluation team identified the groups as being focussed primarily on social isolation or alcohol, or a combination of the two. The breakfast group identified as both social isolation and alcohol focussed and the coffee morning as alcohol focussed. Both groups appear to have been started by the TOML project as drop-in groups and advertised to TOML service users in the respective areas. For the coffee morning group, invitees included residents at a care home which cares for people with cognitive impairment. The art group at the care home dates from the beginning of TOML and is aimed at residents with Korsakoff's Syndrome or acquired brain injury. The Knit and Natter Group (social isolation) appears to have been started during the TOML project, and the support worker confirmed that the focus was on social isolation with no specific alcohol focus.

Observations were documented using a template for field notes during and immediately after the observations with a focus on context, content and process of the groups. The observers made written notes during the groups, where it was felt this would not disrupt the group. Further notes were made immediately or shortly afterwards from memory. These notes were used to type up Observation Record forms with two main sections – Notes/Observations and Reflections. This facilitated separation of records of direct observations and reflections and conclusions from the observation.

7.2.2 Ethics

Group organisers were asked to give participants information about the research in advance of the observed groups so that anyone who objected to an observer being present could express this or choose not to attend. The observer explained the role and purpose at the start of the session.

7.2.3 Summary of observations

The following points summarise the early reflections from the observation exercise:

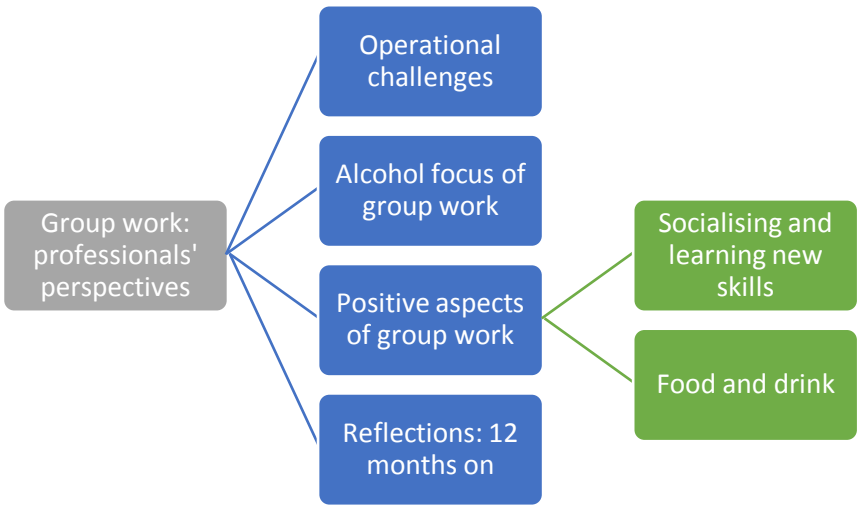
1. There was an overall impression of considerable *commitment and enthusiasm* among the volunteers and peer supporters who led two of the four observed groups.
2. *Combatting social isolation* was a key element of the groups. The degree of focus on alcohol use varied, with the breakfast and coffee morning groups providing opportunities to talk about alcohol issues, whereas the Knit and Natter group seemed entirely focused on countering social isolation.
3. There was a *diverse nature and history of the groups*, with some groups set up by TOML with a clear focus on alcohol, and others where TOML was working in partnership in pre-existing community settings, such as the Knit and Natter group.
4. There was *a lack of awareness of the TOML project* within the social isolation groups in particular. This raised questions about what outcomes for the TOML project might be achieved by the groups without an alcohol focus. It also raised questions about what information partner agencies received about alcohol and whether this was ever promoted within the groups with no specific alcohol focus.

5. TOML groups were evidently *reaching into the community*. The settings of the groups indicated an effort by TOML to reach out into the community. Of the four groups, two were in community settings and one in a care home. The fourth was at TOML's premises in the South quadrant of Birmingham.
6. Issues with *low and fluctuating attendance* were raised during early observations. The difficulties in observing the garden group and very low attendance encountered at two of the groups flagged this up as an area of enquiry when conducting the focus groups.
7. The service users who attended appeared to *engage with, and enjoy,* the groups.

7.3 Findings: professionals' perspectives

TOML support workers lead on the group activities within the project but were not always present at groups. Volunteers run a number of groups with the support of peer supporters. Figure 7.1 below illustrates the four key themes emerging from analysis of the professionals' perspectives on group work.

Figure 7.1: Themes emerging relating to group work from analysis of the professionals' perspectives.



Staff reported that not all service users wanted to attend groups, saying that they 'weren't ready' for groups or 'did not like groups'. Some found their experience a difficult one and felt intimidated about going or had preconceived ideas that it would be similar to an AA meeting and found this off putting. However, staff reported many benefits of group work and group activities. The variety of topics, reflecting the heterogeneity of the service users catered for, range from arts and crafts, information technology, knitting group, gardening group, allotment groups, to coffee morning, drop in, and fishing group with some ideas stemming from group participants.

7.3.1 Operational challenges

It is clear from staff reports that the groups remain the most challenging aspect of the service model in terms of building interest and attendance through scheduling, location,

topic focus (including when and if alcohol is a focus), and then ensuring they remain accessible to new group members.

> …we're still looking at development of groups and things like that and the whole point is that you have to have constant evaluation, a process, you evaluate, you change if necessary. (TOML staff member 3)

> The (name of group) we set up ourselves, and that's every other week. The clients we get there suffer from mental health issues. We used to get up to 6/7 people coming there every other week, but now I've moved it to a different venue where … we're going to start getting up to about 15-20 people coming to this group, so it's going to become a bigger group, it's going to get a lot more from it than what we were before. (TOML staff member 7)

This constant challenge to ensure group attendance is reflected in the closure of at least one group. Some groups were only attracting a small number of people and some staff talked about there being more staff (voluntary and paid) than service users at some groups because of the low attendance. This fed into concerns about ensuring group sustainability by the end of the TOML project period:

> it's monitoring that, which ones are successful, which ones could do with maybe a move of venue, which ones are people finding it difficult to engage clients in, and continuously monitoring, resetting, where we're going... (TOML staff member 1).

When staff were interviewed for the second time approximately one year later, some reported a perceived increase in numbers in particular groups. They also identified examples of where people began TOML involvement by attending groups but moved on to seeing a practitioner.

Reasons for low attendance ranged from weather impacting negatively the outdoor groups to people's reluctance to travel, to benefit problems affecting their ability to pay for public transport. One person said it was important to establish the reason people did not want to attend even if it appeared to be "the silliest thing" because that could be addressed.

Additional operational challenges for staff in relation to groups included ensuring that they were not dominated by one or two individuals and that people were engaged in groups through creative activities. There was a perceived need to overcome people's expectations of what a group might be like, often based on their experience of attending AA meetings in the past. Another concern was ensuring that the person did not become dependent on the group, but participated in the community in other ways as well.

7.3.2 Alcohol focus of group work

There was agreement that all groups were designed to help overcome the social isolation experienced by some people in older age, although the groups differed in the extent to which they retained a formal focus on alcohol. Some staff felt that the focus on social

isolation would have benefits for alcohol consumption without directly addressing it, while for others it was overtly discussed in groups, albeit in a less formal way and once relationships were established.

> …yes we're an alcohol agency but again it's social isolation, use of time and that kind of thing, so they might not have many alcohol issues at all, or any at all, but they're coming to us because they want the use of time and being able to learn new skills. (TOML staff member 5)

> If anybody went in talking about drugs, alcohol or gambling, there wouldn't be groups. You really have to build them from… if it's a coffee morning, let it be a coffee morning before you start bringing in that, "You know alcohol and liver disease and how this can happen and how that can happen, how alcohol affects people and memory and dementia." Before you bring all that in, build it up and they will be interested because they are going through it… ." (TOML staff member 2)

One member of staff commented how the social and activity groups helped people to open up about their drinking:

> I had a client, I suggested she come to a group she said, "Oh, I don't want to sit round and talk about alcohol," and I was like, "Oh no, they're not that kind of groups."… So she came to the breakfast club, had an amazing time because [someone] was there with his guitar and they were singing old songs and I had to leave before the end of the group but a volunteer gave me the feedback later that just before she left she started talking about her drinking with other people. So actually it was fine for her to talk about her drinking but it just came about in a natural way, so that was good. (TOML staff focus group member)

One TOML staff member felt there was good value in getting people to join a social group as this could be a vehicle for subsequently giving them information on alcohol. Another described explaining "carefully" to group members that the group was run by an alcohol service and stated the response from the group was positive and some of the group members became volunteers.

The focus of the group activities and discussion within them varied according to the group but the newer support workers were clear that it wasn't about support workers setting the agenda for discussion, it was up to the group to decide. This would be determined by the mix of people who attended.

> I know in the past support workers have said, "No talking about politics, no talking about religion and no talking about this," and a big list. I used to get quite frustrated as a volunteer because I used to think, "Well, that's life. That is what people talk about." So now we'll talk about anything. (TOML staff focus group member)

One respondent felt that the balance between activities and the alcohol focus needed to be kept given they were a specialist alcohol service, possibly reflecting the different perspectives of more experienced staff:

> I think you just have to watch that sometimes, that people don't suddenly set up lots of activity groups and I was saying, "Why are you setting up lots of activity groups and we're a specialist alcohol service?", I just have to remind them that's part of what we're needing to do, but we can't be doing all of that because that's not in our remit. (TOML staff member 11)

Some support for this concern could be found among staff who reported very few TOML service users attending groups:

> … when I started working in the…group, what I realised was they didn't really know what we did and it was almost like it was just kept under the radar that we were an alcohol service because no one using that group was a service user. (TOML staff focus group member)

However, the lack of focus on alcohol was defended by staff who had seen the changes to people's lives:

> Our clients individually say, do you know what, I was really reluctant to come, didn't want to come out of the house and I'm scared, and now 'when you're doing the next one, I want to come again' … so when you hear those things it's like, "Yeah". To the outsider they might [think] what on earth has this got to do with your remit, but we can see it working. (TOML staff member 1)

7.3.3 Positive aspects of group work

While there were operational challenges and differences of view about the breadth of the groups' focus there was agreement about the positive aspects of the groups.

Socialising and learning new skills

Many staff identified overcoming isolation, learning new skills and being able to chat and build friendships with others as the real positives of the groups.

> …once they've come to a group they've met somebody else and they've met a few people who probably have the same sort of issues, but today are like, "Oh, I'm off to the library tomorrow" or "I'm off to lunch with so and so," "I'm off to bingo tomorrow night." It just starts a whole new chain reaction of, "Oh, I was interested in bingo but I just didn't go, didn't know it was on." Just conversation, communication starts. (TOML staff member 2)

> … doing these groups enables us as workers to say, "This is how you set up an email, this is how you use Facebook" and they're reconnecting not only just with the alcohol but with their family members and them being able to

> see pictures of their loved ones on the internet and all that kind of stuff.
> (TOML staff member 5)

Staff also gave examples of people in their 80s wanting to learn IT, particularly email and skype, to help them communicate with family and friends. Some staff spoke directly about helping people to use their time or keep busy rather than sitting in isolation at home. Others reported seeing friendships and informal peer support developing and building over the course of the group work.

Food and drink

It was also apparent that food and (non-alcoholic) drink were an important factor in the groups and relationship building.

> The breakfast club, if someone is not eating very well, they can always rely on the fact that on a Thursday morning, they can come here, have a crumpet, a piece of toast and a coffee because they might not be able to afford that and sit in a safe surrounding, safe environment with a peer supporter, a member of staff they can talk to if they've got any issues …
> (TOML staff member 5)

Tea and coffee were on offer at all the groups and a couple of groups offered sandwiches and lunch, some of which were provided by peer supporters of their own volition.

Staff described groups as providing progression for some service users – either from home to group activities or, from learning new skills in groups to becoming peer supporters, or volunteers.

7.3.4 – Professionals' reflections – 12 months on

Group attendance 12 months on tended to vary with staff aware that some groups, e.g. art and IT, were not working well or had not recruited as many people as they'd hoped. Numbers reported varied between 2-40 people depending on the group. Staff reflections on the reasons for fluctuation in attendance ranged from insufficient advertising to poor weather to group dynamics or the stigma of being in an Aquarius building. However, some groups in the building were well attended particularly coffee mornings. As one of the measures to monitor groups one respondent spoke of the introduction of 'mini reports' after the group activities and completed by volunteers being attached to group registers. A development that might help improve attendance was that attendance at groups crossed some quadrant borders allowing people from different quadrants to attend groups of their choosing.

7.4 Findings: service users' perspectives

Service user data were collected in two ways; i) through individual interviews and ii) through focus groups held with people attending group activities. Individual interviews were held in people's homes or at a mutually convenient location by prior arrangement. Focus groups for people attending TOML group activities were held either in Aquarius offices or in the

community venue where the group activity was being held. The reflections of people attending focus groups drew on their experience of groups and training courses they attended as part of the TOML support on offer. Three focus groups were held comprising a total of 14 people.

- Focus Group A was held at one of the community group venues where the group activity focussed on social integration for people over the age of 50. The group activity was attended by, and advertised to, members of community, not just TOML service users. The focus group ran at the time of the group to maximise attendance. Out of an average reported attendance of 16-20 people, 10 attended this focus group at the start.
- Focus Group B was attended by members of three TOML activity groups – a drop-in breakfast group, gardening group, and art group. Attendance at these activity groups, on average, was reported to be 4-5, up to 5, and 2 respectively. Two people attended this focus group.
- Focus Group C was also advertised to TOML clients. The focus group ran at the time of, and in the location of, the TOML drop in group. Attenders at this group were more likely to be current drinkers and at an earlier stage in progression through the service. TOML staff stated the average attendance was 8-15 people. Six people initially attended the focus group. This dropped to two as a result of two members' objecting to the grounds on which confidentiality would be broken and two others feeling frustrated at their colleagues' objections.

The following themes (see Figure 7.2 below) combine responses from people interviewed individually and people who attended the focus groups.

7.4.1 Feelings about groups

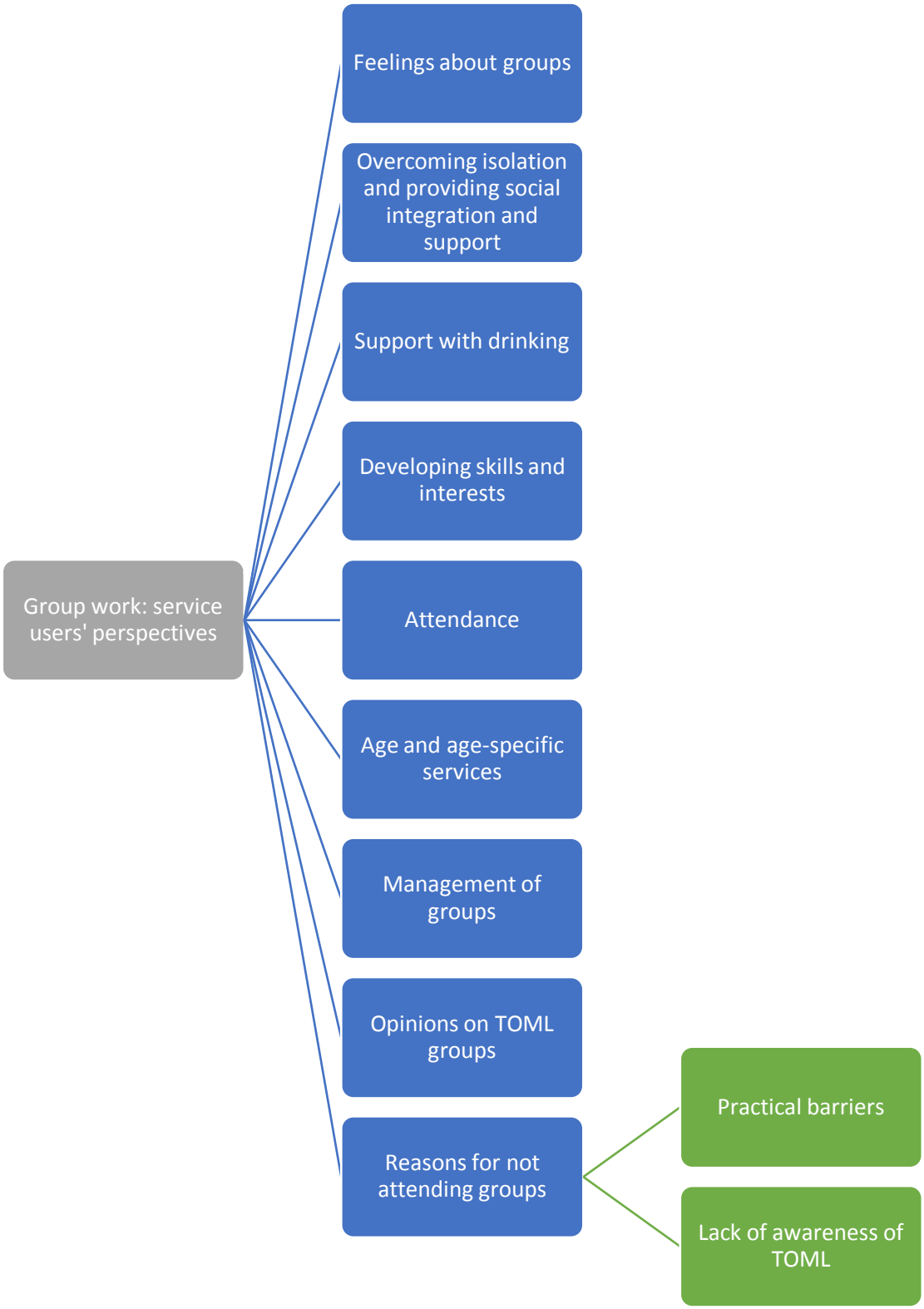
It was evident that joining a group was a big step for some participants:

> Interviewer: Were you quite anxious about going to the group the first time if you're not a groups' person?
> Participant: Yeah, absolutely. [The worker's] face when she saw me, it was like, 'Oh God, you turned up'!
> (TOML service user 3)

Other participants reflected on the difficulties in joining and participating in a TOML groups. However, the small size of the group, the opportunity to share problems, and the informal tone was helpful:

> When I first started to go I felt a bit anxious about it. Then after a while it was okay and because they were alcoholics, because they were like me, that was the one thing that was ... I actually thought that actually made me feel more comfortable because I knew that they were like me. But the AA was different because there's so many people there. I mean these groups were quite small, there were only about seven or eight people in them and in the women's groups it was even less than that. (TOML service user 10)

Figure 7.2: Themes relating to group work from service users' perspectives.



> At first I found it very, very difficult. I was embarrassed more than anything, but after a couple of weeks and then you hear of other people's problems and then you start thinking, "Well hang on. My problems aren't that bad after all considering I've heard that problem." You start thinking and then it just went from there. (TOML service user 13)

This informal tone, relaxed environment and opportunity to socialise was evident in other people's comments:

> Before Christmas I sometimes went to the Breakfast Club at Bristol Road. … But since then I've not been well so I haven't been. But it was good to chat with people there who were at different stages. I met someone who was from Winson Green and I used to live there years ago so we could reminisce together. (TOML service user 16)

It became apparent that some participants had attended short TOML courses on alcohol use and effects delivered to groups of service users, including one respondent who referred to four weeks of group sessions on alcohol and its effects:

> … I think there was about 8 or 10 of us went in the church hall and people from Aquarius, I forget their names, they were brilliant and sat round a table and discussing things with the human body and how it damages you and it was so interesting and I was gutted that that finished, it was only for four weeks and I was gutted. (TOML service user 2)

7.4.2 Overcoming isolation and providing social integration and support

As with the professionals' perspectives, service users spoke about the opportunity for social interaction provided by the groups. It was mentioned in all the focus groups, and was the main objective of the group not specifically aimed at TOML service users (Group A). Key elements of this social interaction were mutual support (of a more general nature than that focussed around drinking) and social interaction with other older people, different ethnic groups, and in different localities.

For some, the interaction was linked to progression from problems with drinking but for others it helped overcome the impact of social isolation associated with age or other circumstances:

> What motivates you to come, you meet people, you get used to people. I kind of like a routine which you enjoy which I needed anyhow. So for me art, garden, coffee mornings, it's just got me back on the ladder. (TOML service user, Focus Group B)

> So I'll probably see [TOML friend] around or meet up for coffee or something outside the actual coffee morning. So I think it's actually doing a really great job of bonding people together, linking them, which wouldn't normally happen. So it's a very good thing the coffee morning. (TOML service user, Focus Group A)

> What's good about [the group] is that when you're over 50 you do get isolated and so you're meeting people. As one of the ladies did say in the group before, when you talk together you realise that everyone has their invisible problems. You talk to each other and you get to know everyone's issues to a certain extent, which means that it limits the isolation you can feel when you're older. Especially in a mixed community where there are different communities they don't automatically mix that much. (TOML service user Focus Group A)

> I think it's important we mix with different communities because in this area it's got a bit of a troubled record in terms of community relations. It's quite nice to really meet people that are from all over the place who you normally don't interact with. (TOML service user, Focus Group A)

In addition to social interaction, participants in Group A spoke of it enabling them to provide support to each other through exchange of telephone numbers. In addition, all three groups mentioned the Christmas and Diwali parties and outings organised by the TOML service. The Diwali party included printed information on the history of Diwali and related children's activities.

As with the professionals, participants in two focus groups referred to the provision of food and hot drinks as being a feature of their group attendance:

> Participant 1: Yeah social and the sandwiches and the free coffee.
> Participant 2: Yeah drink as much as you can get.
> Participant 1: And the sandwiches that are left over you get to take home with you. (Participant, Focus Group C)

7.4.3 Support with drinking

Participants in Focus Groups B and C referred to features of the group activities that specifically assisted with managing drinking. For one person, the groups acted as a simple distraction from drinking:

> Obviously when you're here you're not thinking about the booze or going down the pub. (TOML service user, Focus Group C)

For others who were involved for longer, the distraction was more complex, involving various aspects of what the groups offered, including providing a reason for getting out:

> Well for me it's getting out, like away from what I was doing. Meeting people, gaining confidence to come out and do things, which it has. I'm a lot better than I was two years ago, so for me to come here and sit and talk, or doing the gardens ... You just took me away from whatever, so that, for me like, still is [important]. I've met loads of people [whereas before] I'd never come out. I'd just sit in my house with my bottle of whatever and I'm more outgoing now than I was. I still have my days off,

but it works for me, it really has. (TOML service user, Focus Group B)

As with the groups not focussed on drinking per se, the groups also gave participants an opportunity to share problems and support each other.

> I really look forward to coming. I've only missed one group I think and I felt really gutted about that. Because it's like meeting people and if you want to just have a chat and get things off your chest. (TOML service user, Focus Group C)

> Talking to people and seeing where they're at basically. Because you know I've been there and got the t-shirt. It's like supporting people as well as a team and talking to people. (TOML service user, Focus Group C)

The usefulness of mutual support specific to drinking came through strongly in group C. This included an element of comparing one's own progress with that of others:

> I mean I must admit you do see some people who are struggling and rattling. But it makes you go home and think about you might have been there yourself and got the t-shirt for that one. (TOML service user, Focus Group C)

> And that was like in a group and it could be ... It was really helpful you know. I've been to other groups as well, and you see people it's the same, different stages. It makes you really think how lucky I am like, you know, to have the support and all the network. (TOML service user, Focus Group C)

7.4.4 Developing skills and interests

As with the professionals, service user participants stressed the importance of participating in activities as part of their recovery process, and re/gaining self-confidence. Responses reflected the fact that many of the group had been involved in art and gardening groups. In relation to the art group, developing skills and the stimulus to spend time on activities outside of the group sessions seemed important:

> … [the groups have] meant a lot to me, I've become an artist clearly. They seem very good, it's part of my recovery as well so I'm very positive. (TOML service user, Focus Group B)

> Participant 1: It encourages you to do something. I can draw anything from animals to cartoons. You know anything. When I'm in this place I can do that. I've gone from birds everything haven't I?
> Participant 2: Well there are at least four of your paintings on the wall; birds, goofy, there's a kingfisher there on the wall. I've done all that from here, I do stuff at home as well like. But being around who's here, I just feel like it's pushing me on like, I feel like I've got to do it? (TOML service user, Focus Group B)

> … I do my art on Wednesday and my gardening on Thursday and the allotment on Friday, and my canal work then starts next week. Without all those events that were going on through the week, I don't know what I'd do. I really don't. If they were to stop then I'd probably carry on with the allotments because I've got to know some of the allotment staff there over the period. I'd probably just get an allotment but it wouldn't be the same. (TOML service user 13)

7.4.5 Attendance

As noted by the professionals, the operational challenges of groups often included maximising attendance and needing to vary the location and focus of the groups if they were not working. As some groups predated TOML funding and were then continued for over 50s only, this had an impact on some service users' experience:

> It's hard for me. They took away some of the people here which I've got used to and I could talk to. Everything's like ... I can't explain it, it's gone, all that was gone, all it had done. You know people have moved on. (TOML service user, Focus Group B)

Participants were aware of the concerns about the viability of groups:

> … the art teacher intimated to me that she was going to close the group at Christmas time, but one of the ladies has just come back. So we've got three of us, herself and two of us and if [another person] comes back, the group will keep going. So it is going to keep going that's one good thing. (TOML service user, Focus Group B)

In Focus Group B, there was continuing concern about attendance levels and initiatives to overcome this were discussed, including leaflets, provision of transport, and group members assisting with recruitment. In Group C, a 'drop-in' group, one participant regretted the variable attendance, but there did not seem to be the same concern about persistent low attendance. Group A was clearly well attended, although participants there were keen to see it expand.

7.4.6 Age and age specific services

There were mixed feelings among group participants about whether having specific services for older people was important. One person felt that a group aimed at over 50s was needed and welcome:

> … it's very nice to have something for our age group, because a lot of money does go towards things set up for young people and young adults. This is the only thing I know that's for us before you get to the point where you need to maybe to have some kind of official care or you're not able to manage anymore. It's that in-between part of your life and this group caters for that phase. (TOML service user, Focus Group A).

In the other group where this was discussed - Group B – members explained that their Art and Gardening groups had pre-dated TOML and had at that point included people under the age of 50, prior to the transfer of the under 50s service to another provider as a result of recommissioning. Some saw the loss of these members, and the consequent drop in attendance as a negative development, and were unconvinced of the benefits of an age specific service – at least in relation to the groups:

> Well I can say it would be good to have a younger mix, it's worked hasn't it younger people here? ….it was a good mix and we all get on. I don't think it's just about older. (TOML service user, Focus Group B)

7.4.7 Management of groups

Participants were complimentary across the groups about the way the groups were facilitated. A number of characteristics were highlighted. Knowledge was valued in the art groups:

> Participant 1: Well as long as you're getting the right person in the right job. In the art group we have a very good lady who's very knowledgeable in what she does and she can do - not just the painting of the mosaics and other art works of various types. Whatever she wants us to do we do it and that's that. She leads us well. …
> Participant 2: I think she's brilliant, you can talk to her as well. We're just a happy little group aren't we? But she's very good at what she does. She's very knowledgeable.
> (TOML service user, Focus Group B)

In Group A, being pro-active and striking the right balance between directing and encouraging members to take the initiative was valued:

> The staff are working really hard now, we've only done this ... This is our fourth time, but the staff are working, they keep working, which is proactive in rather than being reactive to something. So they are trying to move the group on and giving the group more impetus and asking people what they want to do. Which is bringing everything out with everybody. (TOML service user, Focus Group A)

In Group C, in which members included more current drinkers, being able to manage challenging behaviour was mentioned as important:

> There's only one thing upset me, where somebody like kicks off, started having an argument. I got a bit unnerved about that, but it was all controlled. But that unnerved me a little bit because people obviously come here to get help and not want to start fighting each other. (TOML service user, Focus Group C)

Some concerns specific to the gardening group were raised which seemed to be associated

with frustration at not having the resources within the group to keep the large garden at the level it had once been.

7.4.8 Opinions on TOML groups

The topic guide included questions specifically asking participants for self-evaluations about how much difference the groups had made in relation to their drinking and life as whole. Variations in the question were determined by the nature of the group activity and the openness and cultural appropriateness of asking about people's drinking. Participants were asked to rate their group from one to five in terms of how much difference it had made to their drinking and life as whole, with five meaning a lot of difference and zero meaning no difference at all. As the question was asked towards the end of the focus group, some participants had left before the question was asked (particularly in Group A). However, the ratings made by participants in each group is shown below in Table 7.1.

Table 7.1: Ratings from service user focus group participants about the difference TOML groups made to their drinking/lives

Rating	Group A	Group B	Group C
Question focus:	Difference to Life	Difference to drinking and life as a whole	Difference to drinking
5		3	2
4	3		
3	1		
2			
1			

This shows that most participants gave a rating of 4 or 5, indicating that they felt that the support they received had had a significant impact on their life and/or their drinking. However, this is only a small sample and clearly not representative of the views of TOML servicer users as a whole.

7.4.9 Reasons for not attending groups

Six interview participants gave various explanations for not attending the activity groups. Some people simply preferred one to one sessions only or they stated they already had an active social life or preferred just the company of immediate family. Another was put off by experience of groups in another alcohol service where the group also included people with problematic substance use.

Practical barriers

Practical barriers included being at work during the day when groups were held and the cost of travelling. Travelling to the TOML groups was, not surprisingly, a common concern, with lengthy journeys by public transport putting off a number of participants:

> I walk with a walking frame and I can only walk with the frame, I know where Aquarius is but apparently, where I get off the bus, is a really long

> walk from the bus stop to where Aquarius is and I'm unsure whether I'd be able to do it, with it being a long distance. Taxis, you can't afford taxis every day. (TOML service user 2)

A couple of participants made reference to the service providing bus passes for a while, and one respondent suggested these had to be withdrawn due to funding difficulties:

> … they used to give us a travel pass and then X who was in charge … said, "As from today that's your last travel pass." I said, "How come?" She said, "They've stopped it." We can't afford to give them out anymore, but my gripe was I'm coming from home, I'm working four or five hours over here and it's going to cost me. She's going, "I know, but it's out of my hands." (TOML service user 13)

Lack of awareness of TOML

Participants in Focus Groups B and C tended to come to the group via the TOML service and referral by GP. However, those who hadn't come directly through the TOML service were often unaware of TOML and Aquarius. Referral to the group occasionally appeared ad hoc or word of mouth:

> …I was at the bus stop waiting on a bus and a lady asked me if I'd like to come to a coffee morning in the area on a Tuesday. Obviously I live on my own and it gets me out of the house, it gives me something every week, a place to go and meet people and make new friends. (TOML service user, Focus Group A)

In group A, participants spoke of gradually becoming aware of Aquarius as organisers of the coffee morning, and of learning what Aquarius did:

> I mean I didn't even know that Aquarius existed and I didn't know what that service related to. That's something I'm learning more and more, so hopefully as time goes on we'll be a bit more aware of what the staff are trying to achieve and what is actually happening. (TOML service user, Focus Group A)

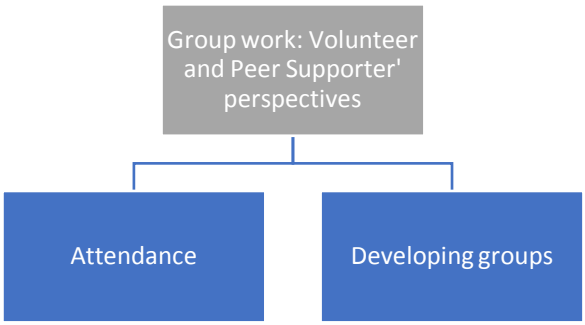
> Well I know Aquarius is there for people with drug and alcohol abuse and stuff like that. I know they're there for that, but they've embraced everybody else as well. So … that's been a general help, but I think as well there's not that much information given outside. (TOML service user, Focus Group A)

In groups B and C, where participants came via the service we found that not all were aware of Time of My Life as the name of the service, particularly those who had been service users of Aquarius before the TOML project started.

7.5 Volunteers' and peer supporters' perspectives

The volunteers and peer supporters are key staff for the provision of group activities within the TOML programme. Two main themes emerged from the focus group with the volunteers and peer supporters that related to group work.

Figure 7.3: Themes from analysis of volunteers and peer supporters focus group regarding group activities.



7.5.1 Attendance

There was some concern expressed by volunteers and peer supporters about group attendance levels in recent months, specifically at the breakfast club. In contrast to the service user focus group, this was not explicitly linked up to loss of activity group members when the adult service was recommissioned and the group became over 50s only.

The volunteers and peer supporters were clearly concerned to maximise attendance and linked the development of their role to home visiting directly to promoting the groups. They spoke positively of a meeting with the volunteer coordinators which discussed volunteers going on client visits to promote the groups and encouraging practitioners to raise the groups with clients:

> … they got … peer supports and volunteers involved and we all sat round the table and said, "What's your ideas?". I felt that we were listened to there and the outcome has been successful in as much as we've been trying to target the practitioners to make the people that they visit aware of the groups and invite them along and of course, if you've got a volunteer going with them, the likes of [volunteer's name] he can go out on a home visit with a practitioner or even on his own… (Volunteer and Peer Supporter Focus Group Participant)

Participants also spoke of discussions about providing transport for clients to attend the groups, although it had not been possible to implement this other than for one off events such as the Christmas party:

> Participant 1: They do keep looking at minibus or whatever and they are

now talking with other established people in Birmingham, DATUS and Changes UK and that who have got a minibus and maybe the use of that, so we are looking at that.
Participant 2: Maybe we could do something like sharing the running costs and have different takes on things maybe. (Volunteer and Peer Supporter Focus Group Participants)

7.5.2 Developing groups

Volunteers and peer supporters made suggestions around organising physical activity for a TOML group recognising that, for some people, like other groups, it could promote reintegration into the community:

> Participant 1: Somebody mentioned it to me the other day about the gym, when I was out with a practitioner, he asked how he could keep his mind off alcohol and I did say, "Keep fit's good, have you got a gym?", so it might be something worth thinking about.
> Participant 2: I think the benefit to that is it's like all the clubs, instead of doing a bit of keep fit in the house with some exercise equipment, it gets you out the house and gets you into society and talking and meeting with other people again, which is valuable. (Volunteer and Peer Supporter Focus Group Participants)

The possibilities of partnership activity with the local authority, making use of the local *Be Active* scheme and other Aquarius classes outside TOML groups were also mentioned.

7.6 Family members' perspectives

Family members' comments suggested that three of their relatives had attended Aquarius or TOML groups (although one of these apparently only attended once). They presented a range of reasons why the groups were helpful. Some felt that it was something that distracted the relative from drinking, even if just a short period of time, others that it encouraged a hobby, while another felt the group had shown her relative that he wasn't alone:

> There's something in the calendar. It's an hour when they're not drinking so I think there is good value in it. (Family member focus group participant)

> She is keen on art and she now goes to three art classes, three/four a week, painting, which she loves, it gives her satisfaction, she is quite good at it but it also removes the excuse of, "I'm bored"… (Family member focus group participant)

> He went to the groups that they run, which I think is also vital, because that helped my dad a lot to appreciate that he wasn't the only person like that because I think they all think that it's just them, they're the only ones going

through it, but to go to a group where other people are or were like that and have come out the other side made him feel a little bit better. It didn't stop him drinking but it made him understand it and he could talk to those people about his situation and what he was going through. (Family member focus group participant)

7.7 Discussion

The group activities component of the TOML project appears not to be designed to address alcohol consumption in a formal way. None of the groups focussed on the discussion of alcohol in a way that a structured group, for example, an 'alternatives to drinking' group might, or an alcohol support group similar to mutual aid formats such as SMART (Self Management and Recovery Training) groups. The group component of the model appeared designed to address social isolation primarily and the need to support people in an informal way with activities to build their confidence, interests and friendships. At times alcohol was part of the conversation of some groups but none were focussed around it as a topic for discussion.

The groups have mixed heritage – some were started anew as part of the TOML project, others were Aquarius groups run under a different banner before the loss of the core services, and others still had a long history of community focussed groups where people were not TOML service users nor where they aware of the groups being run by an alcohol, drugs and gambling charity. The question this raises is 'Does it matter?'. The decisional balance for TOML and Aquarius is one of costs vs benefits and whether the groups meet the aims they set out to achieve for the numbers targeted.

The wider focus on social space and addressing social isolation is both a strength and weakness of the groups. It is apparent that the groups are highly valued by people who attend but attendance varied greatly from group to group with some groups closing as a result. Others attracted a regular small number of attenders, while only some of the coffee mornings or breakfast clubs appeared to regularly attract larger numbers. Staff were aware of the challenges and demonstrated a reflective and proactive attempt to develop groups and engage people. Arguably, the numbers attending groups is only one criterion by which to judge the groups' success. It may not be appropriate to have 25 people in the art or allotment groups given the additional time and resource implications this would have for staff and volunteer facilitators.

Service users stated one barrier to attendance was transport – a service wide survey of service users' views on reasons for non-attendance at groups could establish whether transport is a barrier for a significant number of people and underpin future initiatives and funding bids for transport costs or resources.

As well as addressing social isolation for those who attend, the groups arguably have a prevention role both as a 'distraction from drinking' as one service user stated but also as a peer support mechanism. However, it is difficult to measure or quantify the distinct contribution the groups make to individual alcohol behaviours as they are only one part of a wider TOML service provision.

A positive of the group work is also providing peer supporters the opportunity to work alongside the TOML team and develop their own skills and confidence as they transition from service user to someone who has experience that can benefit others. Given the current 'recovery' agenda of encouraging people to integrate, substance free, back into employment (in the broadest sense) and the community (H.M. Government 2015), this could be strengthened as one of the aims of group activity provision and packaged as part of bids to support people in their transitions into the community.

7.8 Summary and recommendations

Group activities are an important component of the TOML model as the main service that directly addresses concerns about social isolation among older people with alcohol problems. They also remain the most challenging element of the model in terms of engagement and retention of group members, the extent to which they address alcohol consumption (if at all), and the demands on staff and service resources given low and inconsistent attendance. However, they also provide development opportunities for service users, peer mentors, and volunteers and are well received by those who attend. Decisions about group continuation will need to be grounded in the aims of the groups and whether these are demonstrably achieved at a reasonable cost.

Recommendations

1. Continue to monitor the attendance and focus of groups in line with the TOML project's objectives.
2. Review the continuation of groups at which there are no or few TOML clients and whose needs are not social isolation *in addition* to alcohol-related support. (There may be good justification to continue a 'community group' if it serves as a preventative measure and provides a way to access particular communities with alcohol information providing a) it is providing alcohol information and b) that this type of community social group meets TOML project objectives).
3. Consider options for shared transport arrangements or other travel support to maximise group attendance.
4. Future research may include outcome measures that explore health and wellbeing.
5. Further collection and analysis of data which identifies a) how many people attend groups as part of a wider TOML package, b) how many people attend groups only, c) how many people attending groups are TOML clients, d) how many people enter the 1-1 service following group membership, e) whether groups are a source of volunteers and if so, how many, and e) what percentage of volunteers and peer supporters supporting groups have progressed from addressing their own substance problems into a volunteer and peer supporter role, would help to shore up future decisions about viability and function of the group activities.

Chapter 8 - Family work

Key messages

- TOML seeks to adopt a whole family approach and professionals report being able to offer more time to family members than would be possible in the parent service, Aquarius.
- Family members were all accessed through their relative receiving TOML support, with some family members subsequently choosing to take up the opportunity of 1-1 support.
- Support for family members varied and could be providing information and education on alcohol, or it could be emotional support.
- Family groups were not running during this evaluation which could suggest the challenges of group work identified previously extend to family member groups.

8.1 Introduction

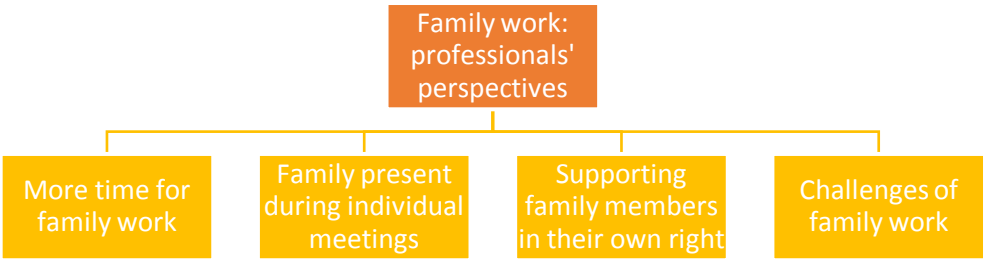
Chapter 2 outlined the model of the TOML project including its aims to support families of older people with alcohol problems. Its parent agency, Aquarius, adopts a whole families approach and this has been continued within the TOML project. Two types of support can be offered to family members, i) family members in conjunction with their relative, ii) family members in their own right. This chapter outlines the findings from professionals and service users in relation to TOML's family work to date.

8.2 Findings: Professionals' perspectives

One of the key differences with family work within TOML project compared to the main service was the wider range of family members staff reported working with. These included adult/older children as well as partners. Family groups were not running during the period of this evaluation; much of the family work seemed to be done on home visits or when family members accompanied the service user to an appointment.

Four key themes emerged from the analysis of the professionals' data relating to working with families. Figure 8.1 (below) illustrates these themes and sub themes relating to family work.

Figure 8.1: Themes relating to family work from the perspective of TOML professionals



8.2.1 More time for family work

While the main Aquarius service has been working with family members in their own right for some years, staff reported having more time and being able to undertake a greater depth of work with family members within the TOML service:

> …this service [is] able to offer more time and the staff are very good at trying to facilitate joint sessions at the home as well, with family members and I think there have been some really good successes ... so I think that whole family aspects is really important in this service, very important. (TOML staff member 11)

> I think family members have far more direct access to getting to services themselves… it is different because it's a much broader approach really, in terms of engaging with families and very often, partners will come with their partner to a group, they'll come and join in with an art group for instance or they'll come and join in with other things … . (TOML staff member 10)

8.2.2 Family presence during meetings with individual

Professionals discussed a range of relationships with family members. In the main, these were with family members who were supporting or driving the efforts of their relative to seek help for their problematic drinking. They provided examples of family members who sat alongside their relative encouraging them to be open about their drinking, and others who phoned up with information on their relative's drinking.

> The time that I do work with family and carers is if they're in the session at the same time when I'm working with the client, and if the client has said 'yes I want my family to be a part of it or for carers to be a part of it' I will do a joint kind of session (TOML staff member 7)

> … in the west and it's like the most ethnically diverse and I find that I'm working with family, so some Asian families, everyone's in the room during the session and everyone has their turn and it is really lovely and often they're there also for translation as well. So that's been a positive experience. (TOML staff focus group member)

> …we're in contact with his daughter because it's almost we're both looking out for him so if there's something she thinks is important to tell us about his drinking, his drinking habits which he hasn't told us for whatever his reasons are, she'll phone us up. Yeah, so we have contact with them and it's important. (TOML staff focus group member)

8.2.3 Supporting family members in their own right

The TOML model views family members as service users in their own right as well as a concerned other for someone engaged with the service. However, there were far fewer instances of family members receiving a service in their own right reported but it did happen in a range of ways. Support can be face to face or long distance over the telephone. Staff provided examples of daughters living 100 and 150 miles away who wanted support but could not attend the service:

> … so I think although sometimes they can't be involved because they are 100 and something miles away, as long as you're keeping them up to date and they're keeping you up to date, it opens the doors. (TOML staff member 5)

> … one of my clients… we see his wife and him separately and then we see them together. So it's to see, obviously, her on her own, see how she's doing, what's going on. She wants to see us on her own as well. … It gives her a respite as well and she's aware that she's not on her own, that we are trying to help and she's very supportive. (TOML staff focus group member)

Discussions were not only to update people and provide information on, for example, prescribed medication and alcohol but they also offered bereavement support:

> … if one of our patients dies we will always go out of our way to offer a service to the family members, to help them in dealing with it. Especially if they've been involved in treatment whilst working with the patient. I think that's really important that we don't just say, right well okay your mum or dad has died now, our work is done, we're closing the file. It's important that we follow that up with that support. (TOML staff member 4)

8.2.4 Challenges of family work

Family work and the different relationships and needs of family members were clearly a key part of service provision, combined with balancing the needs and rights to privacy of individual service users. Supporting family members was not without its challenges particularly where a number of family members were involved or where the household family dynamics were difficult. Some staff reported fractured family relationships or relationships that hindered rather then helped the person's efforts to change. Family were reported by some professionals to be part of the individual's 'recovery capital' if they were supportive but not if they weren't:

> I think if the family members are there and visible straightaway, that's really good, but I've had clients whose family members are not useful to their recovery because they're emotionally beating them up about alcohol use, so I've offered to talk to family members. So they've gone, "Oh, yes please," and then they back out and go, "No, please don't." (TOML staff focus group member)

Nevertheless, trying to retain family relationships in some capacity was seen by one participant as important:

> So you've always got to be able to work with the family member, even if sometimes it is a hindrance more than a positive because at some point down the line, hopefully in the future, it won't be a hindrance. (TOML staff focus group member)

Staff reported family members seeking reasons why their relative was drinking problematically and being shocked when something in their history was identified as being part of their drinking motivations but they didn't know about it. Family members were also reported as having unrealistic expectations about TOML 'sorting out' their relative and being angry when that didn't happen in the way they hoped.

> We do work with carers and family members, spouses, partners, ex-partners, supporting them to help them feel, give them advice and support. A lot of people who have got a partner, they want solutions and they want to be part of the solution and they can be part of the solution but also it's about their partner, or the person who's problematically drinking, actively having some self-responsibility. (TOML staff member 3)

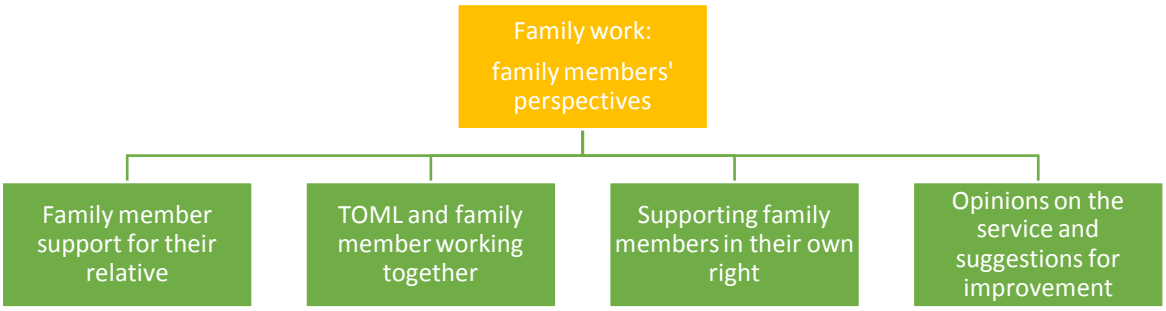
> *Participant 1*: you will get some family members who are really encouraging and they're so relieved that the person's coming to the service and they'll do anything and everything to help and support them. Then you'll get other family members who it's like they've dragged them into the services, like, "Sort them out now. Stop them from drinking now."
> *Participant 2*: Or, "Why haven't you stopped them drinking now?" (TOML staff focus group members)

8.3 Findings: Family members' perspectives

Five family members took part in the evaluation in a combination of interviews and a focus group. Most of their relatives had received support from TOML and Aquarius before that for a number of years including detox treatments, 1-1 support, home visits and some hospital-based interventions. They had also received practical support, for example, with housing benefit forms.

As identified by the professionals, a range of support relationships were available to family members. The following key themes emerged to illustrate the responses of family members (see Figure 8.2 below).

Figure 8.2: Themes relating to family work from the perspective of family members.



8.3.1 Family member support for their relative

Family members discussed the challenges of trying to support their relative and the difficulties they faced in accessing help. For some they were involved in making the first contact with TOML and supporting their relative to accept help:

> … so I became the full time carer of my mum then and I pushed her to get places, you know, get the visits going. She couldn't say nothing once the knock was on the door and I used to let the person in and I got it, kind of, from then. She actually quite liked the people who used to come out when she started opening up a bit … (Family member focus group participant)

While family members were supportive, one person was concerned about whether their relative was able to be honest and accurate about their drinking and attended with him to ensure he told the truth:

> I actually come to his meeting, his Aquarius meeting with him then, because again, I couldn't trust him to tell the truth. I didn't think he would tell and I thought his keyworker needs to know because I just genuinely felt alcoholics are liars, they lie about everything. They don't live in reality because they want to hide from something. As I say, I think that he perhaps became more honest with his key worker, but I don't think she understands or knows enough about my husband to really understand why he drinks either (Family member focus group participant)

In this instance the family member identified a potential lack of understanding on the part of the TOML worker about her husband's drinking. The following section describes how joint working between the family member and TOML team provided support for their relative as well as for the family member.

8.3.2 TOML and family member working together

For some participants, issues around what to say about the service user's drinking to friends, acquaintances and family were important, and TOML staff helped with the difficult decisions involved:

> My wife goes to the church, or did, she has friends at the church, after a

> while you get a bit fed up of telling lies, why she's not here or where she is, "she sounded a bit funny on the phone" and after a while, you realise the best thing to do is to be open. That takes a lot of doing and I was given that advice [by her TOML worker] and I followed that advice and I felt that I was better for it. (Family member)

Support for relatives included family meetings in some cases alongside their relative:

> Well we had family meetings as well where we were still waiting for detox. We felt like giving up. He kept saying, "Well I'm not having it done now, forget it, it's taking too long." So his keyworker set up a meeting for the family so we all came with my dad, had a good talk to him, convinced him that it was the right thing to do … (Family member focus group participant)

TOML service also acted as advocates supporting family members with discussions with health providers:

> Yeah, we're battling with hospitals at the moment and this is another thing that Aquarius are helping us with at the moment. They even went to visit my dad in hospital today and speak to the doctors for us because they're saying that they think my dad's confusion is getting better, but he told us that story two days ago. (Family member focus group participant)

There were some cases where the support given to the family member was of a more practical nature with the relative and the service working together in supporting the service user. This could be in providing information, particularly where the relative was in a position to influence the service user's consumption, and taking on some tasks that might otherwise have fallen onto the relative:

> People did help me as well, they gave me advice and charts with the amount of alcohol in them and provided other service. … You could talk to them about anything really, not just this side, because my mum's got other issues, health issues and things, so they used to help by ringing the hospital appointments for me. It was very helpful like that as well. (Family member focus group participant)

One participant, whose partner had not been to a session for a while voiced an expectation that he would be able to resume contact when needed, while another felt that while her relative had not stopped drinking, the ability to get him out of the house for a while to go to TOML appointments was a help.

8.3.3 Supporting family members in their own right

Direct contact with TOML and the team's support for the relative was evident and much appreciated. Participants also spoke about working together with TOML, feeling that the TOML worker was available when needed, and that TOML's support for the service user took pressure off the family member.

For these family members the individual sessions involved readjusting their expectations:

> I was offered four sessions of one to one for myself, which my expectation was I was going to be given answers as to why alcoholics do this, but then I realised at the end of it my expectations are too high and that alcoholics don't know it themselves and so therefore I can't have an answer and I'm going to have to just accept that. I mean I don't feel I've worked in partnership with Aquarius. (Family member focus group participant)

> … I know that if I'm frustrated about something or need answers about something, all I need to do is send a text and then when they're back in the office, or I can phone up the service and there's somebody there to give me the answers. (Family member focus group participant)

For another, there was an opportunity for relatives to get emotional support and to discuss their own surprising reaction to progress with the service user's drinking:

> One thing that's a bit odd, when we settled down into this pattern of controlled drinking, so I was no longer going home in fear of what I would find when I got home … and suddenly that's not there, I actually started to feel quite depressed, it sounds daft doesn't it? I spoke to [TOML worker] and he said, "I can understand that because you have no time to think, no time to think too much about yourself … (Family member)

> From speaking to someone I learn things. I've taught myself things just by observing my own actions and stuff and how I could actually protect my own life and my own time and stuff, where before I guess I was allowing him to damage my life. Yeah, so it did have huge benefit. (Family member focus group participant)

For a younger relative who saw himself as a carer, regular meetings with a TOML worker provided important support not previously available:

> Initially the learning process of learning how to manage my life and do the best that I could do to help my dad. I guess where it felt it had the most impact for me was, for instance, if I had a meeting once a month I'd keep a list of stuff that I wanted to talk about, stuff that I'd normally just supress or wouldn't tell anyone, whatever, then I'd just go through that list and sometimes when I'm in a really horrible situation I think, "Oh, this is just crap" and normally I'd just deal with it. I just make a note of it and then it would feel good that at least I can bring it up and tell someone in a month's time, whatever. And walking out of here, I can think of it now, just walking into the car I'd be thinking, "Oh, that feels a bit better after I've told someone." It hasn't changed my life but it feels a bit better to have someone to either affirm my actions doing something or tell me what I can do better next time. So yeah, a big benefit really. I kind of wish I got on it sooner. (Family member focus group participant)

Another source of support to relatives was simply the knowledge that the service user had the service looking after them and taking responsibility, and this took pressure off the relative:

> So I was actually really glad that someone else out there was looking out for him because he lives on his own and we were at work all day, so I was really glad that there was other people out there that were concerned about his welfare and were actually going to be doing a safe and well check if I hadn't have called at that time. (Family member focus group participant)

8.3.4 Opinions on the service

Participants were asked to rate TOML in terms of how much difference it had made to them in supporting their relative with 5 as a lot of difference and 1 as none at all. One participant left early resulting in four possible responses. Three of the four rated the service as 5, with one family member emphasising the breadth of support given:

> Five, because they are there when I need them. They're a phone call away. They've offered me personal support. They've offered us family support. They've offered my dad individual support and even though he's in hospital and going through the detox they're still there to support. He's still going to the hospital to visit my dad, he's been twice, whereas he doesn't really need to do that at the moment because there's not a role for him because he's in hospital but he's been twice. He's even been there today to support us with fighting the doctors, fighting our cause for them to look into it further. That is going above and beyond what they need to do really, I personally feel. (Family member focus group participant)

The other participant opted for 3-4 on the basis that some of the support predated TOML involvement and some was on her own initiative:

> So I'm really a 3 to a 4 because I haven't used Aquarius in the same way … So I think that's important because, as I say, the carers need it as much as the person who is suffering. (Family member focus group participant)

8.4 Discussion

It is important to acknowledge that a key limitation of these data is the sample size on which these findings are based. Only five family members were available after several attempts by TOML staff and the evaluation team to arrange contact. The final sample comprised two partners and three adult children. One person had to leave the focus group after 15 minutes resulting in data from four people – two partners and two children. Further research is advisable with a larger group of family members to establish a fuller picture of family members' experiences of TOML.

At the time of the evaluation no family group was run by TOML. This may reflect some of the challenges of facilitating groups (see chapter 7) combined with the need for an 'out of hours' service for family members who are working. The work with family members, therefore tended to be joint work with the family member and their relative with the problematic alcohol use, or individual work with family members. The latter was provided flexibly with telephone support for family members who lived away from their relative. It also continued beyond the time when the relative was involved in TOML, with an example of a family member receiving support following the death of their relative.

Historically, the focus of harm from a relative's problematic alcohol use has been on the impact on younger children of drinking parents, both in terms of parenting capacity and safeguarding concerns. However, the impact on adult family members, be they children or partners, is vitally important in terms of both their own needs and providing a supportive family environment in which the person with the alcohol problem can live as they transition out of problematic drinking behaviours.

The work with family members fits well with the TOML model and ethos. Supportive significant relationships are an important part of helping someone to change, and sustain, changes in problematic drinking behaviour (Tracey et al., 2005; Copello et al., 2000). They are one corner of the 'safety net' that needs to be in place for people seeking to change problematic drinking (McCarthy and Galvani, 2004). Family work needs to be part of the holistic support package TOML offers.

An established body of evidence identifies the negative impact of problematic alcohol and other drug use on family members' physical health as well as their mental and emotional health and wellbeing (Orford et al., 2006). It also shows how working with family members in their own right, not just alongside their relative, can support them to improve their health and wellbeing (Orford et al., 2006). It can also support them to cope in different and perhaps 'healthier' ways with the difficulties and stresses of living with someone with an alcohol problem (Orford et al., 2010).

But not all family support and involvement is positive. Some staff spoke about needing to deal with family members' unrealistic expectations about treatment and their frustrations about their relatives' behaviour and reticence; there was also very limited reference to the potential "hindrance" some family members can pose.

An important part of family and friends' work is the consideration of dynamics which are abusive or controlling. Staff did not raise the potential control issues that can present in family meetings nor the fact that family members could be coerced into attending or feel restricted in terms of what they may say in front of their family. This does not mean they were not aware of it. However, given the well-documented link between alcohol problems and victimisation/perpetration of domestic violence (see Galvani, 2010 for review), it is important to ensure all staff, volunteers and peer mentors are trained and comfortable in asking questions about abuse. It is also important that such questions are asked when family members are not present.

8.5 Summary and recommendations

Supporting family members in their own right and working with family members as part of their relative's recovery is part of the holistic model of care that underpins the TOML project. This was delivered in different ways including face to face and telephone support, with and without the relative with the problematic alcohol use being present. Experiences from the few family members who took part in the evaluation were positive and staff felt that supporting family members was also an important part of the service offer.

Recommendations

1. Further research is needed with a larger group of family members to determine their views on, and experiences of the TOML service.
2. Consider service provision out of 'office hours' to maximise support offered to family members who work.
3. Review whether training on alcohol and domestic violence/elder abuse is in place as part of a rolling programme for all TOML staff, volunteers and peer supporters.

Chapter 9 – Reflections on service delivery

Key messages

- Staff learned quickly that working with an older client group required them to adopt a change in attitudes and approach to their practice, although there remained some evidence of stereotypical assumptions. Specific changes included:
    - Staff spoke strongly about the increased level of skills they needed to work well with this older client group, particularly in relation to patience and listening skills.
    - Staff were working with a range of health issues and had to adapt their practice accordingly, often working with hospitals and other health professionals.
    - Models of practice for mainstream services were not appropriate for this client group who often a) had complex needs as a result of age-related health conditions and b) had lived far longer with problematic alcohol use.
- The location of service delivery held great importance in terms of ensuring service access. This applied to the availability of home visits but also the knowledge of appropriate community venues for group work.
- Key challenges include time pressures and having such a small team for such a big City. Staff were sometimes frustrated at the limitations imposed by a lack of staff resource.
- Working with the new central Birmingham provider, CRI (now CGL), presented a number of operational challenges for both service users and staff.
- Few service users identified areas for improvement but among those who did suggestions included longer hours and greater flexibility in appointment times, the need for more staff, and concerns about changes in staff.
- The volunteer and peer support staff had been more firmly embedded in the TOML service during the course of the evaluation period. Their range of tasks and responsibilities had also grown but there was a need to improve referrals to the visiting service and to increase service availability.
- Volunteers and peer supporters felt greater promotion of TOML project was needed to ensure they were reaching socially isolated people.

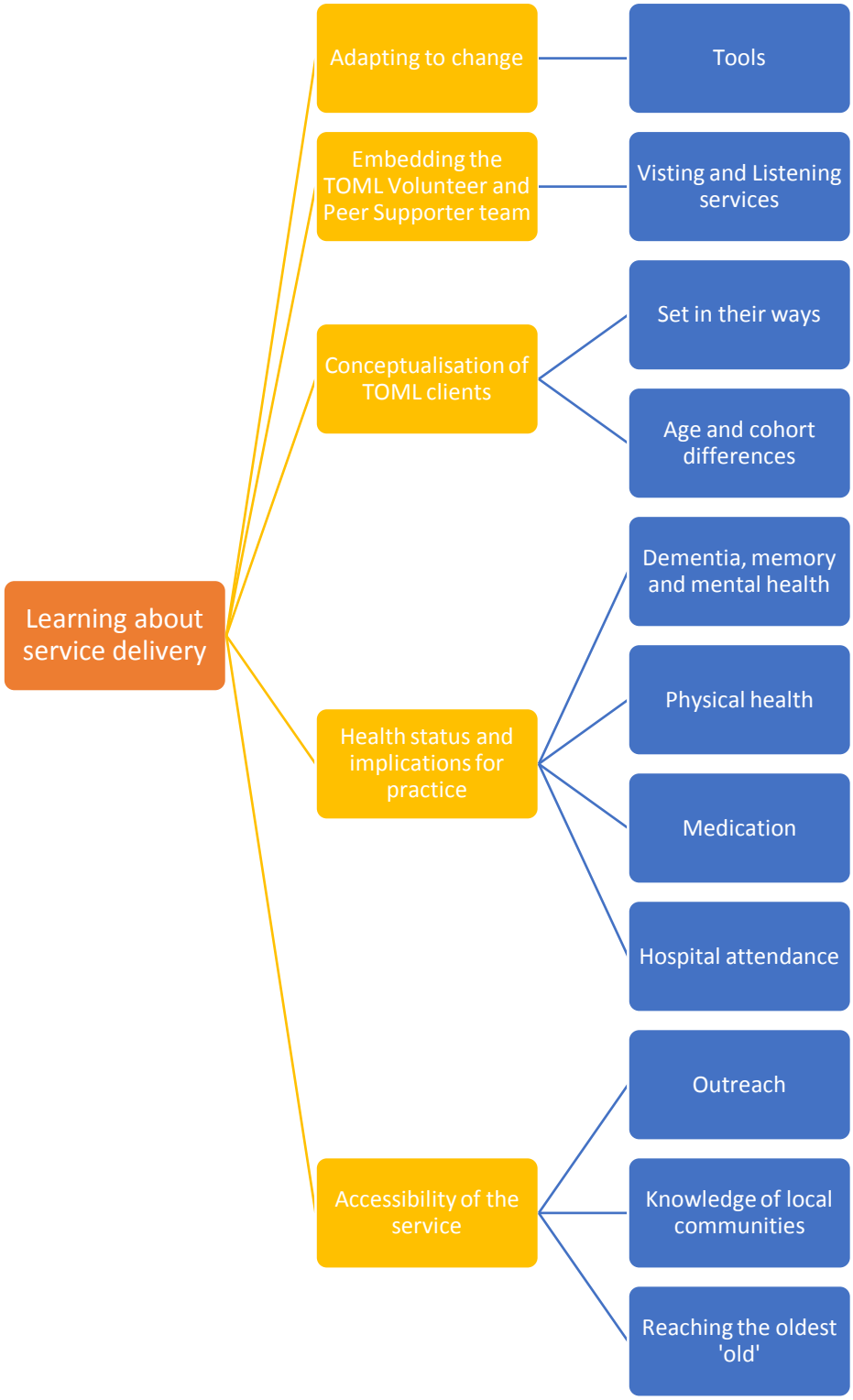
9.1 Introduction

One aim of the evaluation was to identify lessons about service delivery to this particular group of people, their families/carers, and other professionals during the first year of the TOML project. These emerged in both time 1 and time 2 interviews with professionals as it was apparent that there was a quick learning curve in some areas of service delivery while other lessons and reflections emerged over time. The following section highlights the reflections and lessons learned, and the challenges of delivering the TOML project as well as reflections by service users and volunteers and peer supporters.

9.2 Learning about service delivery

Figure 9.1 illustrates five key themes emerging from the analysis of professionals' data.

Figure 9.1 – key themes from professionals' reflections on learning about service delivery



9.2.1 Adapting to change

Five staff reported a change in the demand for the service in the previous 12 months, with increased numbers of referrals and increases in particular aspects of their work; for example, family members both as relatives supporting a loved one, and presenting for support and information in their own right. There had also been a reported increase in email requests so more online responses were part of the project. Staff also reported an increase in people in need of support around mental health or alcohol-related dementia issues and the team had secured a supportive working relationship with a specialist in Wernicke-Korsakoff syndrome. Staff generally reported an increase in demand for the service with some people noticing how their caseload had increased and the impact this had on the time available to spend with people.

> I think rather than seeing people for an hour or an half and a half if needed I've had to pick and choose my clients almost. Well, not pick and choose the clients, but pick and choose how long I was going to spend with a client. … I've had to look at that and go "well, if I need to see six people today, are you a check in or are you a bit more than that? What are your needs?". (TOML staff member 5)

Staff also reflected on a number of staffing changes with a completely new support work team and promotion to practitioner for one support worker when a practitioner left.

Tools

Some respondents reported using more tools from the mainstream service than they had previously, for example, the focus wheels, cycle of change and decisional balance tools. It was not clear why these tools were not used previously however. One professional reported using the manual developed by mutual aid organisation SMART in their interventions. This had the advantage of knowledge about the SMART approach to discuss with service users considering using the mutual aid SMART groups in the community. Assessment procedures had also changed with the introduction of a new assessment form which allowed a greater depth of assessment and could be used without being "tick box paperwork".

9.2.2 Embedding the TOML volunteer and peer supporter team

It was apparent that the volunteer and peer supporter service was embedded far more in the TOML service than 12 months previously. The volunteer and peer supporter team were employed more frequently in a wider range of tasks. More use of volunteers was reported in terms of home visits and running groups with both being seen as a "massive" help. Some volunteers were now leading on home visits and assessments with another volunteer to accompany them. They were also involved in running events and promotional work. As one member of staff pointed out:

> What it's done is where we can say, well, we've got eight paid staff, we've not, (we've) got double that because you've got more feet on the ground and they're people that are really passionate about the service and what we're delivering. So they're going out there and giving their time and really

> doing some really good work alongside us…. it's good for them to just link in with service users and just check in with them see how they're getting on, see how they're doing and then report back to myself. It just gives you a bit more of a head start when seeing people. It's maximised what we can do. (TOML staff member 4)

> … we recognise that we wouldn't be able to do half the stuff that we do, do without a contribution really of our volunteers and peer mentors and that kind of value around someone who has the experience of having an addition, being able to support people at the beginning of the process of change… I think has been huge, and really important for people to get that integration and sense of hope from people that have done it already, so yeah. (TOML staff member 8)

A newer member of staff felt the volunteers and peer supporters were contacted directly in a way they had not been previously:

> A lot of the Time of My Life staff will just ring up the volunteer, "Are you free today?" or "Can I book you in?" Whereas that wasn't really happening before. They were there and they help with the groups but that was, kind of, it. Now it's really running now. (TOML staff member 12 – T2)

Visiting and listening services

The listening and visitor services had been rolled out and developed well in the last 12 months with an increase in referrals from staff into the listener service in particular. Both visiting and listening services appeared to be far more established than 12 months previously with some staff reporting that the services were valued more highly.

Professionals still clearly rated the services as an extra support for service users, allowing them more 1-1 time which they would not normally have time for outside their standard meetings with practitioners – this was the case for both individual service users but also family members. The Listening Service, which is staffed primarily by volunteers, had done particularly well:

> Well if we take the visitors/listeners service first, so the listeners part of the service is soaring really. We've delivered, I was working it out the other day, I think it was over 256 interventions of separate interventions that have been delivered to clients, and I think most of that has been in the last year. It's really picked up as such, so there's been a real surge recently. (TOML staff member 9)

Volunteer visitors had also been able to accompany people outside of their homes, for example, accompanying one TOML client to a course she was fearful of attending on her own.

Some areas for improvement were highlighted. Discussion was still underway about how many volunteers should accompany staff on home visits. The visiting service referrals were

also lower than the listening service referrals and needed promoting more. Some staff indicated that the services could be improved by increasing their availability to every day. One participant felt there was a need for a better resource file for volunteers and peer supporters to access information about other agencies to support their work. Other early lessons were to ensure there was an adequate feedback loop to the volunteers and peer supporters supporting these two services from the TOML staff and to include the volunteers and peer supporters in meetings with the TOML team.

9.2.3 Conceptualisation of TOML clients

Set in their ways

The perception of a number of TOML professionals is that older people are more 'set in their ways' than younger people and this needed to be taken into account in service delivery:

> …a lot of our older, older generation are very, very stubborn and fixed in their ways. (TOML staff member 1)

> I think it's very difficult to change someone's view … they're quite set in their ways. What's the saying, you can lead a horse to water but it doesn't mean they're going to drink. … So I do think some older people can present their own barriers because they're reluctant to do something new or do something that they're not comfortable with in terms of roles. (TOML staff member 4)

Staff stated that this presented a challenge at times for engagement and intervention. They felt that it was often linked to the longevity, both of older people's life course and of their drinking careers:

> They've been drinking for 30, 40 years of their lives and some of them still don't acknowledge that it is a problem (TOML staff member 2)

> …if we take somebody in the older category, they may have been drinking since they're 18, now they're 75, a lifelong behaviour is going to take considerably longer to change than somebody who has developed a drinking problem over the last six months and it's got out of hand (TOML staff member 3)

However, in spite of this view some staff nevertheless highlighted the ability of older people as having both the capability and the drive to change once committed:

> [Older people have] got that sense of, what is the word for it? Not duty, but that sense of, "Right okay, I've started something, now I'm going to see it through to the end, I'm going to finish it" (TOML staff member 1)

> I don't care what age, life can change and everybody is capable of change, no matter what age they are and I think this client group demonstrates that probably more than any other. So it can be a challenge but when you

> see somebody turn their life around, getting out to an allotment, getting out into the fresh air, feeling part of something growing, people get huge benefits from that. (TOML staff member 10)

Age and cohort differences

Staff also spoke about the range of ages in the 'older age' bracket. For the TOML project this ranged from people who were 50 years old and still of employment age to people in their 80s and 90s.

> [Service] delivery can be very, very different and we've also learnt a lot, so the likes of our 50-60 range, might act very, very differently to our 70-80 range, and they need a different approach. (TOML staff member 1)

> We've got two sets of older people, the 50s to retirement age and then retirement age and over, so a lot of the people who are 50 don't look at themselves as being older and sometimes don't even like the thought of being older. You've got the younger older people and the older, older people if you know what I mean! (TOML staff member 3)

Among the differences staff reported between this age group and the wider adult population was the fact that older people could be less comfortable talking about their problems:

> I think it is quite different because I think older people tend not to want to talk about their problems very much. … If you think a lot of people who were brought up in the war years, you're brought up with this attitude that you cope with whatever life throws at you, you cope and you don't complain and you don't seek any help, you just get on with it. (Interviewee 3)

It had clearly been a learning process for the staff in terms of understanding the differences of working with an older age group in terms of their attitudes to, and understanding of, the different approach needed with this group of people. However, the view that older people are 'set in their ways' does generalise a heterogeneous group of people and given the range of people they worked with it is a surprising finding. It may reflect the age difference between staff and service users. It is possible that service users' clarity about what they will and will not accept, or do or do not like - a clarity that often comes with age and maturity - has been interpreted by staff as being somewhat inflexible.

9.2.4 Health status and implications for practice

Staff identified a range of health and well-being concerns with this older age group including people not eating well and having less appetite or poorer diets. Staff spoke of having to accept that with this client group there were 'a lot more deaths' and how difficult they found it when working closely with individuals and their families.

Dementia, memory and mental health

Among the age-specific conditions that staff encountered was dementia (or related conditions) and memory loss. These conditions presented difficulties in offering support as the interventions involve discussion of alcohol-related feelings and behaviours in the recent past. For people with alcohol problems the potential diagnosis of Wernicke Korsakoff's syndrome was also something to be aware of:

> We've got to a stage where we've gone round and knocked on someone's door with a CPN who's been referred with dementia and he's denied that he is who is he. But the CPN knew that he was him, but he'd forgotten who he was, and it's like, with the best will in the world, how are going to do that work? (TOML staff member 1)

> I think you've got the challenges of, like I say, mental health issues, memory issues, that might be diagnosed like dementia or actual memory loss or Wernicke Korsakoff's but actually might just be old age and them being a bit more forgetful. (TOML staff member 9)

> If you're feeling very lonely or isolated or maybe have some memory loss, having a drink and then forgetting that you've had a drink and then having another drink, or just drinking because it's a coping mechanism, if you're feeling quite lonely and got a little bit depressed, can often build into being quite problematic (TOML staff member 3)

This concern was embedded in a wider concern about mental capacity and ability to make informed decisions and provide consent.

A related observation was a higher number of people with TOML compared to the normal service with co-existing mental health problems such as depression, anxiety and post traumatic stress disorder (PTSD), with the latter among veterans in particular which made the need for partnership working more important than ever.

Physical health

In addition, general health problems associated with ageing were also present among the service user group:

> I think the main one for me is the worry that people have when working with older people, due to the risk factors are so much higher, again because of age, ability, health, psychological health, emotional health, whether they're eating or not, whether they've got the ability to do things. (TOML staff member 4)

> There's obviously the additional health concerns with liver problems, potentially arthritis, high blood pressure, heart problems, they're much more at a latter stage within the Time of My Life service, so there's a multitude of health problems that people have to deal with in addition to your mental health and social health as well. (TOML staff member 11)

Staff became familiar with a range of conditions including Parkinson's disease, Chronic-Obstructive Pulmonary Disease (COPD), pancreatitis, arthritis, incontinence and a range of conditions more common among older than younger people and some of which could be exacerbated through excessive alcohol consumption.

Medication

Staff raised the issue of becoming much more aware of people's medication and needing to talk to them about it in relation to their alcohol consumption:

> Then you find they're having half a beaker of whisky and then when you ask about medication, you see that there's contraindications with their medication and it builds up a picture for you of what's happening with that person … (TOML staff member 10)

> They have to have much more knowledge around the health implications, around interactions with, you have to know it anyway but additional medications that they might have because they're older, a multitude of health issues that come with being older… . (TOML staff member 9)

> Yeah and that's, kind of, awkward as well, isn't it, with clients? Because you're trying to explain why all these medications you're on are not working properly because the amount of alcohol you're taking and you'll get some, because of their age, they're adamant, "No, it's always helped," and you're trying to explain, "Well actually it isn't helping and they'd work a whole lot better if you weren't drinking as much as what you are." We get some clients that are drinking well over 100 units a week, haven't we? (TOML staff focus group member)

Staff reported learning more about gaining practice experience of these co-existing conditions and sought to ensure that service users were adequately supported by relevant staff in other organisations, often with TOML staff support.

Hospital attendance

One of the clear differences with this older age group compared to a wider adult age group was the number of admission to hospitals. As a result, TOML staff had learned the importance of close liaison with hospital staff. Although the core hospital work had been picked up by CRI, the agency that won the contract for Birmingham services in the latest recommissioning exercise, TOML staff still worked in the hospitals as a supplementary service to work with people over the age of 50:

> It is supplementary because we're looking for alcohol related admissions over 50 and so can, sort of, go in and screen wards and talk to the staff so that they know the service is available. Sometimes the staff, they're referring into the main alcohol service who then refer into us, or sometimes you pick up a client directly from the hospital. It just, sort of, depends what happens when they go really. (TOML staff member 12)

TOML reported dedicated staff going in to the hospitals weekly to pick up on any new admissions and also to follow up with anyone already engaged with the TOML project who had been admitted to hospital. The relationship with the various hospital teams was extremely important in providing a seamless service:

> …we were invited to go to the [hospital's] development meeting only a couple of weeks ago, which was really positively received and the consultants were there asking us questions about how we're going to support people with alcohol issues in a hospital. So the RAID team, staff on the hospital ward, so we speak to sisters and ward clerks and they will put people in our direction. (TOML staff member 3)

Given the complex health needs of some older people with problematic alcohol use, trips to and from hospital were commonplace. TOML project staff had learned to respond not just to one-off admissions, but to repeat and ongoing periods of hospital treatment and what this meant for drinking behaviour. This included a number of ward visits in hospital followed up with home visiting services:

> I tracked their progress for a good 6-8 months, this gentleman was in and out of hospital, really quite hard to engage in regards to alcohol because when he was in hospital, he wasn't drinking but when he was home, he was bingeing or totally out of it so then that appointment got cancelled, so then I would see him in hospital again. (TOML staff member 5)

> Sometimes treatment, if you've got some quite regular treatment, you've got to expect that at some point, they might go into hospital and then they're hard to get hold of afterwards and treatment does become a bit patchy. So you've got to keep it very tight and if they are in hospital, follow their hospital treatment so when they come back out we can start again. (TOML staff member 4)

Non attendance at appointments by this age group also triggered a higher level of concern than would be expected within a mainstream service with good reason:

> .. we lost a gentleman the other week and if [TOML worker] hadn't have gone on a home visit, even though the guy hadn't confirmed it, because he wouldn't pick up his phone, he would have been dead that day. … You know, [TOML worker] was there immediately, called the ambulance, he wasn't responsive basically, so that's another little point of learning for our staff, is like you know what, if they generally attend or they generally pick up their phone and they're not doing it, we need to be checking that out, and then checking it out a little bit quicker and not just thinking, "Oh, well they just couldn't be bothered to come today". (TOML staff member 1)

9.2.5 Accessibility of the service

Staff reflected that the accessibility of the TOML service was an important aspect of its service offer both on a practical level but also in terms of its value to this older client group.

Outreach

The home visits by staff and the visiting service volunteers were both geared towards supporting people with mobility issues or particular anxieties about leaving the house, although staff were aware that these had resource implications:

> … if they're really well people they will generally come to me. If someone is very elderly, may have mobility issues, struggles to get in and out of the house or are drinking a little bit too much it would be unsafe, I will go and see them at home. (TOML staff member 4)

> I think that's why we get referrals from CRI now because they're realising actually we can't fit round these people's needs, we can't do it, so they'll send them to us now because, older people, they can't get to the big building with the big stairs, you know, they can't fit in with this certain time and they can't come to a morning group because they've got their bus passes that start at half nine. (TOML staff member 6)

Knowledge of local communities

Accessibility was geographical as well as physical. Staff had learned to review, periodically, the fact that some geographical areas did better than others in terms of recruitment – particularly to group activities. Staff knowledge of the local communities was crucial when planning and reviewing this aspect of the work.

> …one of the examples as to why we closed down the coffee morning at the local church was because it was in the wrong location, … it just didn't take off, whether that was because it was in a church because of the religious connotations, people were Christian and didn't want to attend the Baptist church or whether it was too far for them to travel because it was the other side of the city, I think sometimes having them in libraries or community centres is easier for people to access because there's no religious connotation, if it's in a church they automatically think, "Is someone going to be talking Bible at me?" (TOML staff member 5)

> We've tried to split the social/coffee morning interactions across the area, so north is quite a large area but if we look at one of the coffee mornings is in [name of ward], people who live [there], tend to never leave it and it's quite an insular community because they have everything they need, doctor's surgery, community centre, supermarket. So providing that type of social interaction in their own environment is the best way forward because they wouldn't travel to [another ward]. (TOML staff member 3)

> The afternoon tea [group] there's not enough attenders for me … so I'm not going to keep flogging a dead horse, so let's have another look around there, what other areas are we not tapping into and we think we've found somewhere in another area that's like more highly populated, more footfall, venue's a little bit more on the street, so let's have a go at that. (TOML staff member 1)

Because of the differences in the population profile of the City's quadrants there were different challenges for different aspects of the programme. The profile of older people with alcohol problems differed in each area in terms of community focus, cultural and ethnic profile, languages spoken, demand in hospital settings, levels of referrals (higher in south and east), demand for groups vs 1-1 or visiting/listening services. Staff reported ongoing learning about quadrant differences and what worked well and how best to engage people in each quadrant.

Reaching the 'oldest old'

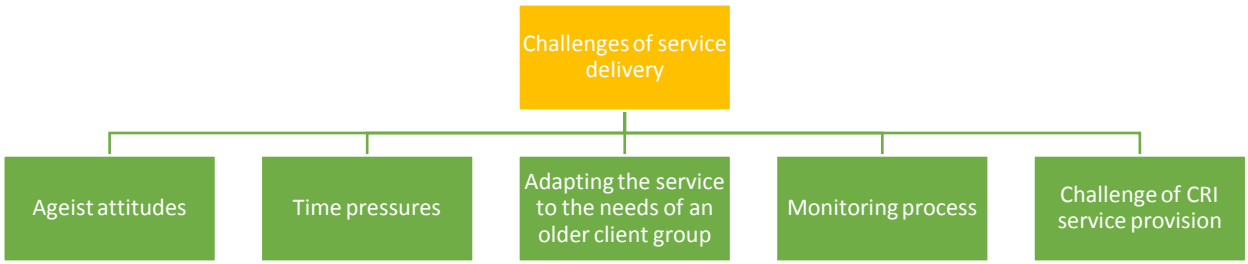
Staff had also learned that services needed to be attractive to the range of age groups within the 'older age' spectrum and that the promotion of the service needed to reflect the older end of the spectrum:

> …you have a lot at a stage where we've got the 50-65 but it's really interesting and really great for us a project to see that we are hitting those older, older people which really are the hidden drinkers and the secret drinkers, and… it's great that referrals have gone up a lot there. (TOML staff member 1)

9.3 Challenges of service delivery

As part of the evaluation, staff were asked to reflect on the challenges they had faced in the first 12 months of the project. Some challenges specifically related to the resources for the service while others focussed on partnerships and attitudes of other agencies towards older service users. Figure 9.2 below sets out the five key challenges identified by staff.

Figure 9.2 – Five key challenges identified by staff



9.3.1 Ageist attitudes

One of the challenges for service delivery for this age group identified by staff included overcoming the stereotypes of other staff that older people's drinking was not something to worry about, and raising awareness of the harms to older people of excessive alcohol consumption. One member of staff commented that engagement could be a challenge particularly when someone was in and out of hospital or had decided they were too old to make significant changes.

However, it was also apparent that some staff held, at best, stereotypical assumptions. Generalisations such as older people being 'set in their ways' or staff expressing surprise that older people may challenge their attitudes to them or not react in anticipated ways to their youth or appearance, indicated at least a set of expectations about how older people behave. To their credit, however, this was usually acknowledged and reflected on in terms of their own professional learning journeys.

9.3.2 Time pressures

Time, in particular, was raised repeatedly by staff in different contexts, as was the small size of the team given the large demand for it. All staff reported high caseloads and high demand. TOML is a small team in a large City.

> … time can be a difficult one because we're such a small team and, [in terms of the] over fifties in Birmingham, there's a lot of people (TOML staff member 6)

> I'd say I'd like to see there'd be more staff … because obviously we've got an awful lot of clients and not necessarily an awful lot of time to see people. … I think having a support worker and a practitioner in a quadrant, one practitioner covers two quadrants, it's limiting the amount of people that we can see and there are an awful lot of people that are being referred and I think they need input and sometimes, because we're limited by the amount of time, that's quite difficult. (TOML staff member 3)

> …if we were a bigger team, we can cover more of Birmingham and have more clients on our caseload … if we had more workers or more volunteers, I could step away from the groups and have more people on my caseload, which means we're seeing more people and getting more people into recovery and back into the community. Having more staff would be great. (TOML staff member 5)

The need for more time than usual for each appointment with this older age group was a particularly strong element of individual service delivery:

> I think for me the challenge is about time, I've said that I think that more time has to be spent probably before you can get to talking about the real issues and then if you are needing to do home visits, there's the time element and I think in this world of cuts and targets and successful completions, a lot of the frameworks within the structured treatment contracts, I don't think fit the needs of this cohort really. So I think that's a bit of an issue. (TOML staff member 1)

9.3.3 Adapting the service to the needs of an older client group

Staff reflected that assessment and visits had to be tailored to the needs and understanding of the individual, including those that are not directly related to their alcohol use, for

example, experiences of bereavement.

They also identified a challenge about supporting family members who were under the age of 50 but whose relative was in the TOML service:

> There's always been a bit of a "what do we do with this one?" when we've had a 37-year-old daughter ring up and saying she wants support. So, who works with that person? Because they're not our age group. What we've been doing, and we've had quite a few of those lately, more so than we've had in the last year, is what we've done is we've done the initial phone call and we've found out a little bit of the information and then we've had one of volunteer listeners call to give support to that person over the phone. And if they want to come in and accompany a family member, that's fine. But we've had a lot more whose family member doesn't know they're ringing up. (TOML staff member 2)

One member of staff reported it as supporting the older person still "but we're supporting them through the back door".

Staff highlighted the need to remind people in this age group about appointments and because many did not use mobile phones to allow text reminders, time was needed to telephone people to remind them. Timing of appointments was also important for some service users:

> … older people like consistency. If you see them at 2 o'clock on a Monday they want to be seen at 2 o'clock on a Monday for their duration of time with us. That's not always possible. And, that is, it doesn't sound like a huge one, but it is a challenge and it's a challenge that sometimes have the poor practitioners tearing their hair out, because if they deviate slightly it's… You can feel like you're back to square one with that client … (TOML staff member 1)

9.3.4 Monitoring processes

The restrictions of the required monitoring systems for TOML were identified as a challenge by one member of staff because they underplayed the project's 'successes'. If someone dropped out of the service for any reason, including dying, it was recorded as an "unsuccessful closure". Another member of staff pointed out that the national monitoring systems and other monitoring requirements were demanding on staff time and that there needed to be care taken not to spend more time on monitoring systems than with people themselves.

> Of course [monitoring] is important but actually, if that really gets in the way of people delivering a service, then we've all lost the plot haven't we really? (TOML staff member 11)

9.3.5 Challenge of CRI service provision

In terms of the bigger picture, the service was running within a broader context of major funding cuts to health and social care budgets, as well as retendering for services that the parent organisation, Aquarius, had been running for decades. Staff were lost to the organisation and core services were transferred to the successful bidder, CRI. TOML staff identified a range of challenges both for clients requiring CRI services and to partnership practice. These included waiting lists for detox, a lack of referral pathways, assumptions by CRI staff that older service users did not have children which may impact on services received, to a lack of confidential assessment spaces within the service.

In addition, the detoxification service run by CRI seemed to be an ongoing challenge and in need of improvement in terms of better partnership working.

> I think one of the biggest things in Time of My Life since the changeover is the fact that Aquarius [had responsibility for] the community detoxes, whereas now we have to go through CRI. Sometimes it works, sometimes it doesn't, but I mean Aquarius, especially now with Time of My Life, they're pushing for better partnerships, better relationships with CRI for the detoxes, because things have gone wrong with various clients. … The system you have to go through at the moment just takes forever. (TOML staff focus group member)

Staff noted that challenges of this transition phase included ensuring that people were aware that Aquarius still existed and that older people, in particular, could access services:

> … after CRI took over … I think a couple of people forgot that Aquarius existed so we had to get out there and tell people about it. We've been able to do that. (TOML staff member 6)

> … because of the commissioning that's happened in recent months in Birmingham City Council, there is quite a lot of issues with … obviously we want to refer people for detox and rehab but the referral pathways are quite blurred and not defined at the moment, that can be quite an issue. (TOML staff member 3)

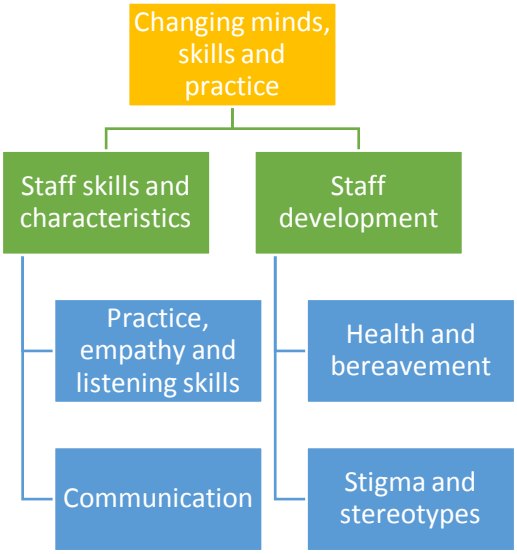
9.4 Changing minds, skills and practice

A further aim of the evaluation was to determine the extent to which the project had changed the minds, skills and practice among the substance specialist staff providing services to older people with problematic alcohol use. It sought to reflect learning and development among TOML staff. Two themes related to this aim:

1. Staff skills and characteristics
2. Staff development

Figure 9.2 below shows these two key themes and related sub themes.

Figure 9.2 – Key themes identified professionals for changing minds, skills and practice.



9.4.1 Staff skills and characteristics

It was highly apparent from talking to staff, even those most experienced in working in the substance use sector, that the TOML project had challenged and developed their skills and practice. There was a clear sense that a higher level of 'fine-tuned' skills were needed when working with this group of people, more so than with their younger counterparts, in order to, for example, recognise if back ache might be kidney problems or falls might be related to drinking.

Patience, empathy and listening skills

One very clear message about practice with older people was the requirement for patience. This was often associated with showing respect and supporting people from the outset in terms of their social isolation.

> … you have to be very patient with people who use substances, when you're trying to support them through the cycle of change and the process of them getting to where they want to be … but with older adults, with the multitude of memory issues, with the way they want to interact with services, you have to be much more patient in terms of where you get to and make goals much more realistic… (TOML staff member 9)

> I think, as a worker in general you need patience in the field, you do, but I think you need an added dollop of patience working with the older generation. And, that's patience in terms of expecting progress because a lot of things are very habitual… . So there's a lot of like myth breaking and stuff going on there, so you've got to be really patient and… sometimes repetitive, with that kind of thing. (TOML staff member 1)

Patience was often mentioned in the context of being able to listen and to demonstrate empathy:

> I think the main skill is … to really listen to the older generation because they've got so many stories to tell that they want to tell, to be more

> patient with them, because they might have … stammers or dementia or memory problems that other clients may not have that you've ever dealt with before, so it's having that extra ability to listen, to sit there and listen to their stories and just be really patient with them. (TOML staff member 5)

> I can't say I'm the most empathic person on the planet and I'm definitely not the most patient, but I've had to be and I've had to really adapt to it. (TOML staff member 4)

> … listening is paramount with the over 50's because what has come across to me is that, "Everyone has stopped listening to us, family, friends. They don't want to listen to us." So listening and there's a lot of stories but amongst there you'll find that this is a trigger, this is what this person could be doing, this could be good for this person. You'll find what they need and then you'll present it to them as an option. … There's always something. (TOML staff member 2)

Communication

Staff also mentioned different types of communication skills in their reflections on the skills base and learning from the TOML project to date. Several participants made reference to having a 'softer' or more 'gentle' approach to assessment, intervention and support than might be normal within mainstream services and, importantly, without being patronising.

One respondent who worked with older people from minority ethnic groups highlighted the importance of language in gaining trust before being able to discuss alcohol-related problems. The sense that staff had to question more and 'investigate' what was happening in older people's lives to determine the best course of action was also a common finding:

> it's hard to explain how that is different, but I think there's almost a bit more detective work that goes into making a thorough assessment, read in between the lines and our use of language as workers, the getting the questions answered but not a direct question… (TOML staff member 1)

In sum, staff were saying that there were no new skills as such but the skills they had needed to be used well:

> I think the set of skills are similar, we just have to have more of them. (TOML staff member 9)

9.4.2 Staff development

In addition to enhancing and applying their existing skills, the TOML project staff had also developed their knowledge and skills. One person stated they were a different person to the one who began in their project role and how they now had far more skills than when they started.

Health and bereavement

Given the sometimes complex needs of this service user group, one of the major areas in

which people identified skill development was in relation to health issues. Staff reported having a range of training courses including Parkinson's Disease, Mental Capacity, First Aid, Manual Handling, Wernicke Korsakoff's Syndrome as well as bereavement training. The location of some staff within the hospital on a regular basis also allowed the acquisition of health knowledge and the ability to use that in their contact with service users.

The need for bereavement training was identified as an important need by both paid staff and the volunteer and peer support focus group participants too, and the group implied this was going to be provided:

> I know that in recent, recent times we've had a look at training for staff around pre-bereavement and bereavement issues, because we find that when you pick up the family members for, if for whatever reason unfortunately the focal client passes away during service, it creates a whole other dimension of support that's required for the family member. (TOML staff member 9)

> Participant 1: Most of us are all down for bereavement training, I think that is one area in particular there which would be greatly helped because we're dealing with people who have either had some kind of loss, either a partner, a loved one, it could be losing their job but it's all various degrees of loss so bereavement training …
> Participant 2: So that's being addressed. The training comes up and I think it's consistent, there's always something coming up, training wise.
> (Volunteer and Peer Supporter Focus Group Participants)

In addition, staff had benefitted from training in relation to interventions such as Motivational Interviewing techniques, Cognitive Behavioural Therapy, and the use of the new TOML specific assessment forms.

Stigma and stereotypes

Staff also had developed a greater understanding of the stigma towards people in older age and were able to reflect on this in the context of the TOML service:

> It's given me a better understanding of maybe some of barriers between society and older people, and how older people are maybe treated. … I think though there is a lot of prejudice towards older people. … I do think in society we do try and provide for everybody but I don't think we do enough. I think that's something that I've seen. A lot of maybe negligence. (TOML staff member 4)

> So my views have changed full circle … because I now understand why [older people have dropped out of services quickly] and I think we were very arrogant to think that the services that we got were adequate enough. We always knew they weren't but there was … an issue around services have always been so over-stretched, not looking too closely at why older people didn't attend, but I think we do have that information now, so my

views have changed. I think given the right opportunities, older people will respond and respond well, not everybody, as in all walks of life … but certainly, enough people to make a difference. (TOML staff member 10)

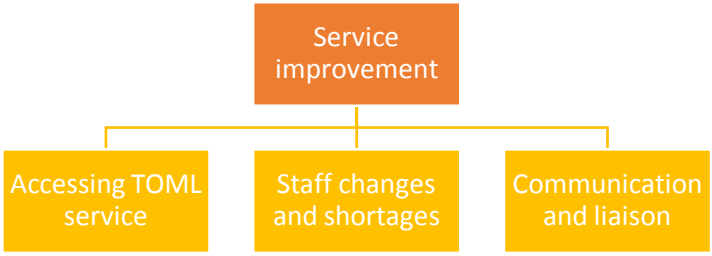
And there's so much drama, there's just as much drama as there is in youth work [laughing] and that's the kind of element that I really naively thought would be missing, I really did. I thought there'd be a lot more routine and stability … and I was completely wrong, completely wrong and I was glad to be wrong on that, because it just taught me again, yet again, … don't assume things about bunches of people, just don't, don't stereotype people. (TOML staff member 1)

There was a very clear sense of commitment to the TOML project. Their reflections on their learning during the first year of the project from both personal and professional perspectives illustrated how surprised and challenged they had been by the demands of this particular group of service users but also how passionately they felt about their work.

9.5 Service improvements: service users' perspectives

All participants were asked about ways in which the TOML service could be improved. The service user group identified three potential areas for improvement but these were largely individual concerns and not widely shared (see figure 9.3 below):

Figure 9.3: service users' perspectives on areas for service improvement



9.5.1 Accessing TOML service

The service has a policy of offering home visits; however, travel costs and anxiety about travelling were noted and underpinned the appreciation of home visits. Some participants, preferred to make difficult journeys to office appointments instead of receiving home visits and in spite of the costs. However, a significant number of service users worked varying hours, and arranging appointments with what was essentially a 9-5 service was often a challenge. For the North quadrant, we learnt of early evening appointments being available at the Kingstanding Leisure Centre on one or two days per week.

We encountered one respondent, whose work patterns were unpredictable and needed appointments at short notice, who could not find suitable appointments and was disappointed to be discharged. Eventually in response to his attempt to phone the worker,

he received a voicemail saying his case had been closed, but he could contact the service again if he wished. The respondent complained of the manner of the communication:

> And, it was just the fact that she went on to say, you know, 'we're not a drop in service, we're a business' and I thought, that's what jarred on me, that's what made me say, I felt suitably rebuked … . (TOML service user 12)

Inevitably, those at work during the day were also not able to attend the TOML groups.

9.5.2 Staff changes and shortages

These comments brought together here seem largely individual concerns. They do, however, raise issues that may require more general consideration.

One respondent spoke of the difficulty in getting appointments, which he saw as partly due to workload pressure on the staff, and appreciated the efforts they made in these circumstances:

> *Participant*: I know he's a good guy and he's working really hard but you can tell just in conversation with him when he's saying there's people on long term sick and stuff like that, it seems from an outside perspective that people are burning out. There's that much workload on them, they'll do their best, do their best, do their best. Because they've got the best intentions, that's why they do the job. But there's that much workload, something gives.
> *Interviewer*: Do you feel that's impacted on you and what [TOML worker] has been able to do directly for you?
> *Participant*: It has at times, yes. Because his diary's that full, when I've got my off shifts, his days are fully booked. So I've had to roll over to maybe the next week or even the following week because his workload's that much. (TOML service user 11)

Another respondent spoke of the difficulties in facing changes in support workers:

> … to get to know somebody for a period of six to twelve months and then get a phone call, you know, the next time you go to see him or her and they say, "Listen, this is my last week here now. I've got to go somewhere else but we'll put somebody in our place," you know, it's a bit of a downer … because you've bonded, if you know what I mean. They know you, you know them, but when somebody else just takes over and she'll say, "Well, tell me about what you've been doing," and you think, "I've got to do all this. I've got to start from fresh," and it can bring back bad memories because it's memories that you've buried and forgot about and you're looking to the future. Does that make sense? (TOML service user 13)

9.5.3 Communication and liaison

In addition, one respondent felt that the service should do more to explain the nature of the service and what outcomes there were:

> So, when you're talking about a service that intervenes you want to actually have some understanding… which is kind of fundamental really, that how do they intervene, what sort of, what are the patterns, what are the outcomes? And maybe it was because we didn't move along sufficiently to get to that point… to give them credit. (TOML service user 12)

Another respondent argued for more liaison with health services, and for TOML to advise on diet:

> It would help if departments spoke to other departments, so if there were closer links with the GP and the hospital. Also they could help people more with diets. I've got cirrhosis and it would help to have advice or a sheet giving advice. They have to strike the right balance and reach out to people, but not be pushy. (TOML service user 16)

Other participants suggested running anxiety management courses or supporting people to get second opinions for medical matters:

> I've told my doctor, I've said I don't believe I'm going to be stuck on my legs. She says, "You are, you're stuck like that through Korsakoff Syndrome." I said, "Well I want a second opinion." Now Aquarius can do with other people who need second opinions. (TOML service user 19)

Finally, one person felt the waiting area for appointments at the Kingstanding office could be improved to make it more welcoming and more private.

9.6 Service improvements: volunteer and peer supporter focus group participants

The volunteer and peer supporters identified one main area for improvement and that was increasing the publicity for TOML. Of course this would have an impact on staff capacity which was identified by both staff and service users as an issue.

9.6.1 Publicising TOML

Participants referred to an inherent difficulty in promoting the service to people who are socially excluded:

> But when you're socially excluded and you're isolated, you don't get the same amount of information, either written pamphlets or internet or by phone call and so until more and more people have got that and their awareness of that is raised, that will still be a problem. But it is getting slightly less. (Volunteer and Peer Supporter focus group member)

They spoke about their involvement in the TOML Newsletter which is produced by volunteers and peer supporters, and their attempts to ensure that they are widely distributed:

> Actually, I'm finding now because we take the newsletters out, we go in the groups and hand them out rather than just sending them to north, south, east and west and presuming they've gone out, then finding they probably haven't … (Volunteer and Peer Supporter focus group member)

They also expressed a desire to get more involved in Aquarius' website and social media presence, for the benefit of TOML as they felt this was not well used at present:

> Participant 1: … I think we've got an opportunity to get information out that's up to date about the different clubs and stuff that we do, I think if [the website] was really up to date and it was looked after and given a bit more priority I think, would be very beneficial.
> Participant 2: I think there is a difference between your website, your Facebook, your Twitter and all that which is on there one day and then you'd scroll down and you've lost that, whereas the actual Aquarius website, some of that could be on there properly and I do find the website really bad. (Volunteer and Peer Supporter focus group participants)

9.7 – Service improvements: family members' perspectives

In response to the invitation to discuss aspects of the service that could be improved, family members raised the issue of funding for out of hours support for both service users and friends and family members, both to cater for crises but also to accommodate people at work during office hours. This was a need that TOML had been able to meet to a limited extent, but there was a feeling that this had been going further than was required:

> Like I struggled to get time with Aquarius in the first place just because they didn't support anyone outside working hours or anything, but they kind of bent the rules to help me, but still, that was appreciated. (Family member focus group participant)

Another strongly argued suggestion was that direct access to detox treatment should be restored to TOML so that it could offer a full service:

> One package to do all, yeah, and not have a bit from there and a bit from there and a bit from there because that does not work … Alcoholics don't want to do that, you know. They don't want to keep going over it. "I've told you once, why do I have to tell you again?" That's exactly what you get. (Family member focus group participant)

Other suggestions included funding for more TOML staff, and to give them their due status and respect:

> When you read the papers, you get the impression that alcoholism and drugs and so on are increasingly prevalent, … we need more people like the [TOML workers] of this world and I suspect compared with, to me he is as useful as a doctor … we should respect the fact that they are professional people, … so I'd like to think that if you made sure that there are enough of them in the country and they are properly rewarded, not just in salary but in professional status. (Family member focus group participant)

9.8 Discussion

The introduction of a specialist service for older people with alcohol problems had presented both opportunities and challenges for the TOML team. It is clear from their reflections on learning and on potential improvements to the service that it had challenged them to develop their knowledge, skills and, for some, their attitudes for working with this older cohort.

The complexity of needs for some of this older age group and the demands this placed on staff and resourcing, particularly in relation to health and social care needs, required effective collaborative working and a degree of advocacy. As demand for the service increased, so too did the need for additional time and resources and creative ways of thinking to meet need including the effective use of volunteers and peer supporters. Reflections on the TOML model and its operational demands suggest the approach has transitioned into a form of 'case management'.

Hesse et al. (2010: 2), in a meta-analysis review of case management for people with "substance use disorders", define case management as:

> … a client-centred strategy involving assessment, planning, linking to relevant services and community resources and advocacy. Its intent is to improve the co-ordination and continuity of delivery of services.

While TOML staff also have the intent to reduce alcohol related harm their role is clearly one of remaining client centred and identifying the person's additional needs for signposting to other health and social care services. Hesse et al.'s review was inconclusive about its impact on reducing substance use as the included studies varied in their outcomes, but it did find that case management was a more effective system of linking people with "community and treatment services as compared to treatment as usual….or psycho-education or brief interventions" (p.2). However, they also pointed out that contextual factors such as the availability of supervision and training or the availability of relevant services to refer to are likely to contribute to the varied outcomes in different areas.

Importantly, they also found that those case management studies that included a manual to guide the delivery of case management increased the linkages to other services. This is a potential way to take forward the TOML model in terms of developing a manual or toolkit.

In a review of effective interventions for social care professionals when working with people

with substance problems, Galvani et al. (2011) found the majority of 57 relevant studies related to forms of care or case management. They highlighted a number of key features including the need for a tailored package of care:

> ...the more complex the needs of the service user group, the more intensive and long-term the form of case management will need to be. (Galvani et al. 2011: 6)

They also found that:

> Approaches that focussed on developing and sustaining a relationship appeared more likely to be linked to positive outcomes than forms of case management which focussed on effective service coordination. (Galvani et al. 2011:6)

This evaluation of TOML has highlighted the importance of having a longer time to work with service users because of the complexity of some older people's needs as well as the importance of the therapeutic relationship to the intervention. The existing evidence also highlighted the need for creatively engaging people through, for example, home visits or out of hours work, consistent and longer term availability of staff, and the provision of additional services and not just coordinating care (Galvani et al. 2011). It also emphasised the importance of skilful communication and engagement often grounded in motivational interviewing approaches. While methods were not discussed in any depth in this evaluation, motivational approaches are one of the main methods underpinning Aquarius' and TOML intervention approach.

At a time when social care provision seems to be moving away from a holistic model of care to more budget driven crisis intervention, it is notable that the TOML model fits well with many of the case management criteria and reflects a wider move within substance use services away from narrowly focussed interventions to a more holistic and ecological model. However, what TOML adds is more 'recovery' focussed activities and support on a more informal level from the volunteer and peer support provision. In this way, the TOML model appears to be offering both case management and recovery support and is a model worth developing and disseminating.

9.9 Summary and recommendations

The TOML staff team is clearly committed to the project and its model and is able to reflect on what has been learned and what could be done better.

Recommendations

1. Lessons learned from practice should be fed into the model dissemination and/or manual or toolkit development.
2. Consideration could be given to framing TOML as a Case Management plus Recovery Support model for older drinkers.
3. Further partnership development work with the new provider CRI (CGL) to facilitate pathways between services would likely benefit service users.

4. Where opportunities arise, funding for additional staff would ease pressure on the small staff team and allow longer hours to cater for working clients and family members.
5. Review promotion of, and referrals to, the visiting service to ensure that service use is maximised.
6. Formalise feedback routes to, and from, the volunteers and peer supporters about their contribution and development needs.
7. Clarify to staff whether there is an age limit relating to family work.

Chapter 10: Training evaluation

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Key messages

- A total of 313 non-substance specialists and 45 substance specialists took part in a TOML training programme **and** completed evaluation questionnaires before and immediately after the training (T1 and T2).
- Only 51 non-substance specialists and 2 substance specialists completed evaluation questionnaires three months after the training programme (T3).
- The TOML training provided to respondents comprised a half day focused on working with older people affected by alcohol problems.
- The non-specialist group comprised a diverse range of professional and vocational roles and a large proportion of social work students.
- Prior training in working with people with alcohol problems was low for non-substance specialists and previous training in working with older people with alcohol problems was low for both groups.
- Based on responses to a study specific questionnaire containing scales for preparedness for, knowledge of, and attitidues towards working with older people with alcohol problems the evaluation found:
    - Substance specialists scored more positively than non-substance specialists at T1 in terms of preparedness to work with adults and with older people who had alcohol problems. The training increased the scores of both groups on this measure.
    - A similar pattern was seen in relation to knowledge, sense of legitimacy and willingness to engage with alcohol issues. The scores of substance specialists were higher than those for non-substance specialists throughout but again, for both groups, scores on all domains were higher at T2. Among non-substance specialists greater increases in attitude scores were seen for knowledge and legitimacy than was the case for engagement (willingness or comfort with working with alcohol users). Scores for role support indicated that non-substance specialists felt more confident about being able to source support after the training.
- Current practice in working with older people with alcohol problems was found to be low on average across both participant groups and T3 data showed little change in this for non-substance specialists (data not available for substance specialists)
- Currrent practice was associated with prior training, preparedness and all four domains of the attitude scale and whether or not they were social work students. Higher levels of current practice were associated with greater levels of prior training, preparedness and higher scores on all four domains of the attitude scale. Lower levels of practice with older alcohol users were also observed for participants who are social work students as opposed to other participants. However, causal links cannot be inferred.

10.1 Introduction

One of the core parts of this project involved the delivery of training in working with older people who use alcohol. This chapter explores the impact of that training on participants' knowledge about and attitudes towards working with older people who have alcohol problems. It also explores the impact on their feelings of preparedness for working with this client group and considers the extent to which participants were actually working with this group (their 'current practice').

Two training programmes were offered, one was designed for practitioners working in a substance use treatment service (substance specialists) and the other programme was aimed at staff across a range of health, social care and first responder services (non-substance specialists). The substance use specialists would have had experience of working with substance users but not necessarily experience of working with older users. The non-substance specialists group comprised a diverse mix of disciplines and professions including student social workers, police officers (and police trainees) fire officers and administrative staff from the substance use treatment agency

The training programmes took the form of a half-day workshop. These were provided on an on-going basis through the first year of the project and were set to continue for the duration of the project. The training focused on promoting awareness of and knowledge about alcohol problems for older people, factors which might act as barriers to treatment for them and the sensitivity needed when working with alcohol problems among this group.

10.2 Methodology overview

A total of 337 people participated in a non-specialist training programme and 45 attended a programme for specialists.

To enable an assessment of the impact of the training programmes, those participating in both types of programme were asked to complete a questionnaire at three time points. First, at the start of the training course (Time 1/T1), second, at the end of the training course (Time 2/T2) (T1 and T2 questionnaires were completed on the same day) and then again approximately three months post training (Time 3/T3). Paper questionnaires were completed at T1 and T2 and an electronic version was emailed to respondents at Time 3.

10.2.1 Sample

Of the 337 non-substance specialists who attended the training, 313 (93%) completed the T1 and T2 questionnaires as did 45 substance specialists.

A substantial proportion of respondents had agreed to be contacted for the T3 follow-up (84% of non-substance specialists (n=263) and 95% of specialists (n=39)). However, in actuality, the response rate at this point was poor. Despite reminders being sent, just 51 non-substance specialists (20%) and only 2 (0.5%) substance specialists provided T3 data. The characteristics of those providing T3 data and the implications for the analysis are discussed below.

Sample characteristics

Table 10.1 below shows the demographic breakdown of respondents to the survey at T1 and T2. Overall, the sample comprised more female than male respondents (58% v 43% respectively). However, this varied by group with more males than females in the substance specialist group. More than 40% of respondents were aged 30 years or younger. There was a larger proportion of respondents who were older than 30 years among the substance specialist group (66%) compared to the non-substance specialist group (57%). The average age of substance specialists was higher than that for the non-specialist group (37 v 34 years old).

Table 10.1 - ***Demographic characteristics of the sample***

Characteristic		**Non-substance specialist**		**Substance specialists**		**All Respondents**	
		N=337	**%**	**N=45**	**%**	**N=382**	**%**
Gender	Female	181	57.1	17	39.5	207	57.5
	Male	136	42.9	26	60.5	153	42.5
	Missing	20		2		22	
Age	30 or under	135	*43.5*	13	34.1	149	*42.5*
	31-39 years	81	*26.2*	13	34.1	87	*24.7*
	40-49 years	62	*20.0*	9	19.5	78	*22.3*
	50-54 years	23	*7.4*	1	2.4	25	*7.2*
	55 or over	9	*2.9*	4	9.9	12	*3.3*
	Missing	27		4		31	
	MEAN (years)	34.4		37.2		34.8	
	RANGE (years)	18-64		22-61		18-64	
Ethnicity	Asian	28	*9.0*	*4*	*9.3*	32	*9.0*
	Black	32	*10.3*	*4*	*9.3*	36	*10.2*
	White	241	*77.5*	*29*	*67.4*	270	*76.2*
	Mixed	8	*2.6*	*5*	*11.6*	14	*4.0*
	Chinese & others	2	*0.6*	*2*		2	*0.6*
	Missing	26				28	
Personal experience of problematic alcohol use	Yes	*56*	*17.9*	*12*	*29.5*	*69*	*19.4*
	No	*256*	*82.1*	*31*	*70.5*	*287*	*80.6*
	Missing	*25*		*1*		*26*	
Ever worked in a specialist alcohol role	Yes	*17*	*5.4*	-	-	*17*	*5.4*
	No	*297*	*94.6*			*297*	*94.6*
	Missing	*23*				*68*	

In terms of ethnic background, the sample was predominantly White, with 77.5% in the non-substance specialist group and 67.4% in the substance specialist group. The rest of the respondents in the non-substance specialist group included 9.0% Asian, 10.2% Black, 4.0% Mixed and 0.6% Chinese and other ethnic backgrounds. In the substance specialist group, there was a larger proportion of respondents with mixed background (11.6%), followed by 9.3% Asian and 9.3% Black.

Almost one third of the substance specialists reported having personal experience of

problematic alcohol use compared to only 18% among the non-substance specialist group. Among the non-substance specialist sample, only a minority of 5.4% had ever worked in a specialist alcohol role.

Table 10.2 below illustrates the professional and role-related characteristics of the sample. In terms of length of time in current role, the overall data indicated that respondents had an average of 4.3 years in their roles. Respondents in the substance specialist group tended to have shorter terms of 2.5 years in their current positions compared to those in the non-substance specialist group who had an average of 4.6 years in their roles. However, given almost one third of non-substance specialists were students these data should be treated with caution.

Table 10.2 - Professional and post-related characteristics of the sample

Characteristic of organisations		**Non-substance specialists**		**Substance Use Specialists**		**All**	
		N=337	**%**	**N=45**	**%**		
Time in current post	Less than a year	105	*36.1*	17	39.5	*122*	*36.5*
	1-2 years	76	*26.1*	12	27.9	*88*	*26.4*
	3-4	15	*5.2*	11	18.6	*23*	*6.9*
	5+ years	95	*32.6*	6	14.0	*100*	*30.2*
	Missing	46		2		*48*	
	MEAN (years)	4.6		2.5		4.3	
Current role	Administrative role	*15*	*4.5*	*3*	*6.8*	18	*4.8*
	Clinical role	*57*	*17.1*	*41*	*93.2*	98	*26.0*
	Student Social Worker	*108*	*32.4*	-	-	108	*28.6*
	Police Officer	*84*	*25.0*	-	-	84	*22.2*
	Fire Service	*70*	*21.0*	-	-	70	*18.6*
	Missing	*3*		*1*		4	
Type of Organisation	Health & Social Care	50	*15.1*	45	*100*	46	*12.2*
	Mental Health Service	16	*4.8*	-	-	16	*4.3*
	Fire Service	71	*21.5*	-	-	71	*18.9*
	Police	84	*25.4*	-	-	84	*22.3*
	University	108	*32.6*	-	-	108	*28.7*
	Others	2	*0.6*	-	-	2	*0.5*
	Missing	*2*				*2*	

Respondents worked for organisations that provide a range of services to different user groups. As expected, in the substance specialist group, all respondents worked in organisations providing services to people with alcohol, drug and/or gambling problems, namely Aquarius, across Birmingham and the Midlands. Almost one third of the non-substance-specialist respondents were affiliated with a university (i.e. student social workers) and this is followed by 25% in the police workforce and another 22% in the fire service. The remaining 20% were involved with organisations related to mental health services (5%) and health and social care (15%).

Importantly, returning to completion rates at T3, it is clear that there were differences in

terms of the proportions of the organisational groups who responded at follow up. The T3 sample comprised 22% health and social care, 22% social work students, 22% police, 18% fire service and 14% people working in mental health services. This equates to only 11% of the original group of social work students, 13% of the fire service participants, 14% of the police officers, 24% of the health and social care employees and 44% of mental health service staff. It is impossible to know why this might be but it can be hypothesised that social work students may have moved on in the three-month time-frame. For police and fire service representatives the focus of the training may not have been perceived as central to their role. Similarly, depending on one's status within organisations, continued employment in the same role within health and social care may be more or less precarious. In contrast to other organisational groups, almost a half of the original group of mental health professionals completed the T3 questionnaire.

Whatever the reasons for the attrition, it is clear that the numbers responding at the follow–up point had significant implications for the planned analysis of change in knowledge, attitudes and practice over time.

10.3 Results

In terms of outcomes evaluation, one of the main research questions of this project was to determine the extent to which the TOML programme had changed minds, skills and practice among both the non-specialist and substance specialist respondents in providing services to adults and older people with problematic alcohol use. The analysis therefore addressed:

- Respondents' experience and prior training in working with both adults in general, and older people in particular, who have problems with alcohol use.
- Respondents' feelings of preparedness for working with people with alcohol issues (both adults in general and older people).
- Respondents' knowledge of, and attitudes toward, working with **older people** who have alcohol issues.
- The extent and nature of respondents' experience in working with older people who have alcohol issues (Current practice).

10.3.1 Prior training and experience of working with people with problematic alcohol use

Table 10.3 captures respondents' experiences of prior training for working with adults and working with older people in relation to alcohol issues. In the survey, respondents were asked to indicate approximately how much training they had previously received on problematic alcohol use among adults in general and older people in particular. They were also asked for details about who provided that training. Available response categories ranged from 'no training' to '5 days or more'. In terms of sources of training, respondents were asked to indicate as many sources as possible which may include employer, university/college, self-study or other sources.

As can be seen in table 10.3 almost half of the non-substance specialist sample (49%) reported they had received 'no training' for working with adults, and a further 23% who stated they had received just a half-day of training. The remainder (28%) had received

between 1 to 5-days (or more). In relation to specific training on older alcohol users, the majority (73%) of the non-substance specialist group had no prior training, although 17% reported a half day of training and 9% had received between 1 and 5 days or more training prior to the TOML programme.

Table 10.3 - Prior training received in working with alcohol and problematic alcohol use

Training for	No training	Half a day	One day	Two days	3 - 4 days	5 days or more	Total
Adults in general							
Non-substance specialist *Missing=20*	49.2% (n=156)	23.3% (n=74)	17.0% (n=54)	4.4% (n=14)	2.2% (n=7)	3.8% (n=12)	100% (n=317)
Substance specialist	-	-	-	-	-	-	-
Older people							
Non-substance specialist *Missing=23*	73.2% (n=230)	16.9% (n=53)	6.4% (n=20)	2.9% (n=9)	0.3% (n=1)	0.3% (n=1)	100% (n=314)
Substance specialist *Missing=1*	56.8% (n=25)	13.6% (n=6)	9.1% (n=4)	4.5% (n=2)	2.3% (n=1)	13.6% (n=6)	100% (44)

For the substance specialist group, respondents were only asked to indicate the amount of training they had received on alcohol use among older people prior to the TOML programme training (on the assumption that they would have received sufficient training for working with the majority adult population). As shown in Table 8.3, more than half (57%) of the substance specialists reported 'no prior training' on alcohol use among older people. The remaining 43% of the respondents reported differing amounts of time spent on training relating to alcohol and older users with 23% receiving half-a-day to 1-day training and 20% 2-days to 5 days or more.

Employers were the main providers of substance use training for our respondents, in both non-substance specialist and substance specialist categories (see Table 10.4 below). In the non-substance specialist sample, respondents stated that training for adult (20%) and older users (15%) was provided by their university or college. This is due to almost one third of the respondents being social work students who were affiliated with a university or college. One in five respondents in the non-substance specialist group had previously attended training for both adult (19%) and older users (21%) provided by Aquarius. Other sources included a range of organisations, for example, Women's Aid, the local authority, or as part of their student placement.

Among the substance specialist group, while a majority of the prior training was provided by employers, there was also a number of respondents who reported training through self-study or learning 'on the job' both for alcohol use among adults (21%) and older people (8%).

Table 10.4 – Source of prior training received

Sources of prior training	Non-substance specialist, Frequency (%)		Substance specialist, Frequency (%)	
	General	Older People	General	Older People
Employers	86 (45.2%)	46 (46.5%)	40 (65.6%)	10 (76.9%)
University/College	38 (20.0%)	15 (15.1%)	5 (8.2%)	-
Self-study	12 (6.3%)	9 (9.1%)	13 (21.3%)	1 (7.7%)
Aquarius	36 (18.9%)	21 (21.2%)	1 (2.5%)	-
Others	18 (9.5%)	8 (8.1%)	2 (5.0%)	2 (15.4%)
Total	**190 (100%)**	**99 (100%)**	**61 (100%)**	**13 (100%)**

10.3.2 Preparedness for working with service users with alcohol problems

Exploring feelings of preparedness for working with service users who experience problems with alcohol was a core focus of this part of the study. Respondents were asked how prepared they felt for working with adults with alcohol problems in general and, specifically, older people with alcohol problems. In the survey, respondents were asked to indicate the extent of their perceived preparedness for practice in eight different areas:

1. Alcohol and its effects.
2. Identifying problematic alcohol users.
3. How to assess risk relating to alcohol use.
4. Reasons people use and have problems with alcohol.
5. How to talk about alcohol issues with service users.
6. Barriers to treatment (i.e. personal, psychological and social)
7. Attitudes and values relating to alcohol and problematic use.
8. Working with, or referring to, specialist alcohol workers.

For each of the eight items, non-substance specialist respondents, were asked to indicate their level of preparedness for working with problematic alcohol use amongst a) adults in general and b) amongst older people in particular on a scale of 1-5 ('1=poorly/not at all prepared', to '5=very well prepared'). In order to aid the interpretation of the findings, the original five categories of response were collapsed to three by combining 'well prepared' with 'very well prepared' into category 1 (well prepared), category 2 was adequately prepared and 'poorly' with 'not well prepared' became category 3 (poorly prepared). These questions were asked at all time-points to assess whether there was any change in perceived levels of preparedness between T1, T2 and T3[9].

[9] Due to the small sample size at T3, a pair-t-test was computed to determine if there was a significant difference in the overall preparedness mean scores between T2 and T3. The result indicated that there was no significant difference for overall preparedness at Time 2 and Time 3. Therefore, analysis of variance (ANOVA) was not computed for overall preparedness across Time 1, Time 2 and Time 3. No comparative analysis was conducted for substance specialists at Time 3 due to poor-response during the follow-up stage.

The perceived level of preparedness for each area at T1 is presented separately for working with adults generally and older people in particular for each participant group (non-substance specialists and substance specialists). Figures 10.1 and 10.2 (below) present first the distribution of responses for the non-substance specialists when working with a) adults and b) older people with problematic alcohol use at Time 1 - the baseline for the study.

As indicated in figure 10.1, prior to the TOML training programme (Time 1), relatively few non-substance specialists felt well prepared in any of the topics (between 15 and 20% on most items) although 29% felt more confident about the reasons adults in general might use or misuse alcohol. The proportions of this group who felt well prepared for working with older people with alcohol problems were markedly small, just 10% to 13% across the items.

The topics in which respondents in non-substance specialist sample felt most prepared when working with adults in general and older people, included:

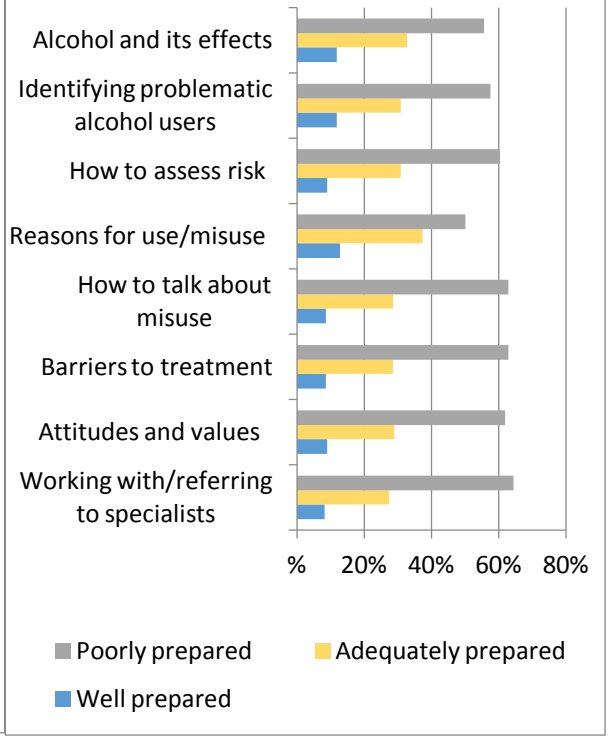
- Reasons people use and misuse (general: 29%, older people: 13%)
- Alcohol and its effects (general: 21%, older people: 12%)
- Identifying problematic alcohol users (general: 20%, older people: 12%,)

Topics which many non-substance specialists felt poorly prepared when working with adults in general and older people included:

- How to talk about alcohol issues with service users (general 54%; older people 63%)
- Working with, or referring to, specialist alcohol workers (general 53%; older people 64%)
- Barriers to treatment (i.e. personal, psychological and social) (general 53%; older people 63%).

Figure 10.1 - Time 1: Working with adults in general

Figure 10.2 - Time 1: Working with older people



Because a greater level of experience was expected among substance specialists, respondents in this group were asked to report the extent of their preparedness when working with adults and older people with problematic alcohol use based on a seven point scale ('1=not at all prepared', '7=extremely well prepared') Again, for results interpretation, the original seven categories were reorganised into three categories, labelled 'extremely well-prepared' (ratings of 6 or 7), 'well prepared' (ratings of 4 or 5) and 'somewhat prepared' (ratings of 1-3).

Figures 10.3 and 10.4 illustrate the percentage distribution of preparedness for the eight areas of working in alcohol use/misuse with adults, and with older people respectively, among substance specialists at baseline (T1). What is immediately clear is that prior to the TOML training, a majority of substance specialist respondents reported that they felt well prepared for working with issues related to problematic alcohol use among adults in general with more than 60% indicating they felt extremely well-prepared and at least a further quarter feeling they were well prepared in all topics.

The three topics in which a large proportion of substance specialist respondent felt extremely well prepared (at T1) when working with adults' alcohol use in general included:

- How to talk about alcohol issues with service users (77.3%)
- Reasons people use and have problems with alcohol (70.5%)
- Attitudes and values relating to alcohol and problematic use (65.1%)

Figures 10.3 and 10.4: Perceived levels of preparedness for substance specialists (T1)

Figure 10.3 - Time 1: Preparedness for working with adults in general

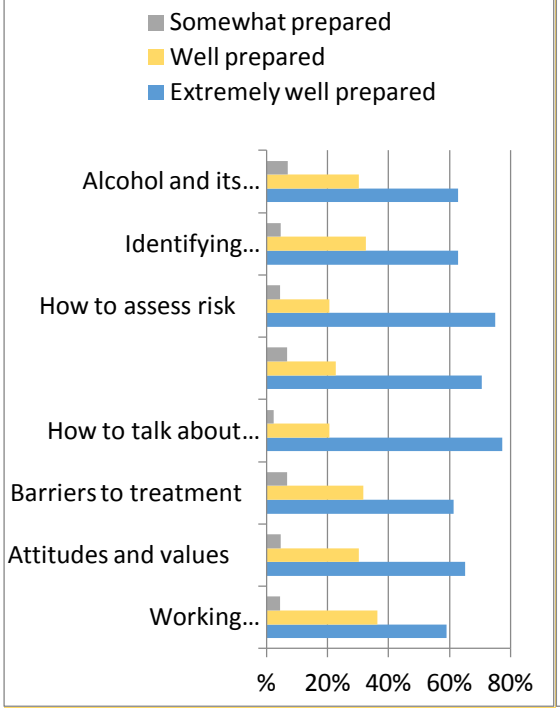
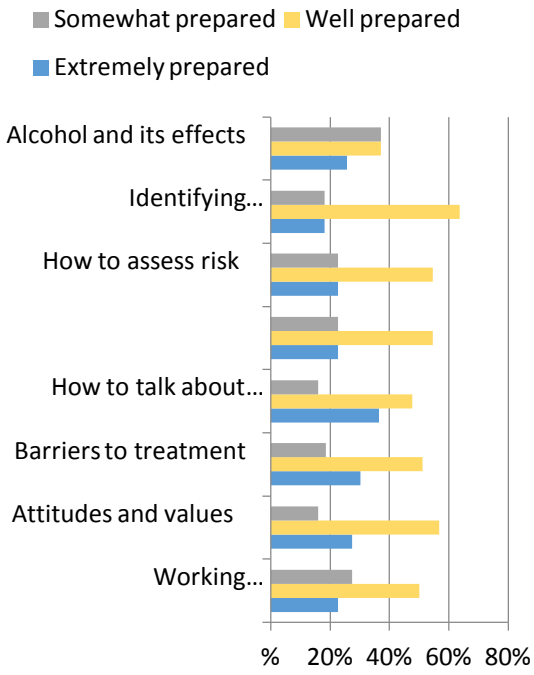


Figure 10.4 - Time 1: Preparedness for working with older people



In contrast, at baseline (Time 1), only one third of respondents in the substance specialist group reported that they felt 'extremely well prepared' when working with older people; while more than half felt 'well prepared' (see Figure 10.4). The three areas in which substance specialist respondents felt most confident in relation to older people were:

- Talking about alcohol issues with older service users (36%);
- Identifying personal, psychological and social barriers to treatment (30%) and
- Attitudes and values relating to problematic use (27%).

Topics in which substance specialists felt least prepared, or only somewhat prepared, when working with older service users were:

- Alcohol and its effects on older people (33%)
- Working with, or referring to, specialist alcohol workers (27%)
- Reasons older people use and have problems with alcohol (23%)
- How to assess risk relating to alcohol use (23%)

Overall preparedness across different time points

As mentioned previously, the original coding of perceived levels of preparedness for each individual item for the non-substance specialist sample, had been a five point scale from 1 (poorly prepared) through 5 (well prepared)[10]. For substance specialists, a 7 point scale was

[10] Non-substance specialists were ask to indicate whether they felt '1=poorly/not at all prepared', '2=not well prepared', '3=adequately prepared', '4=well prepared' or '5=very well prepared' for

used in which individual items had been coded 1 (poorly prepared) to 7 (extremely well prepared)[11]. Thus, for each respondent, a score could be calculated by summing together the response value for each of the 8 individual items, the resulting value was then divided by 8 (the number of items) to produce an overall preparedness mean score. This could range between 1 and 5 for non-substance specialist respondents or 1 and 7 for the substance specialist group. Based on the average, the lower the score (closer to 1), the lower the level of perceived preparedness. The higher the score (closer to 5 or 7), the higher the level of perceived preparedness amongst respondents. Results from reliability tests for both participant groups across different time points reported high levels of internal consistency with Cronbach alpha values ranging from 0.94 to 0.98.

The average mean scores of overall preparedness for both groups of respondents across different time points are presented in Table 10.5 (below). As can be seen, among those in the non-substance specialist group, the average scores at T1 (prior to training) were low, with means of 2.6 (s.d. = 0.8) and 2.3 (s.d. = 0.8) for perceived preparedness when working with adults and older people respectively, which is closer to an average response of 'not well prepared'. After attending the training programme, the mean scores for overall preparedness at T2 increased to 3.78 (s.d. = 0.8) and 3.77 (s.d. = 0.7) for adults and older people respectively (closer to an average rating of 4 (well prepared)).

Table 10.5: Overall preparedness for working with adults in general and older people at different time points

	Non-substance specialists, Mean (SD)				**Substance Specialists,** Mean (SD)		
Overall preparedness	Time 1 (T1)	Time 2 (T2)	*T-value (T1-T2)*		Time 1 (T1)	Time 2 (T2)	T-value (T1-T2)
Adults in general	2.63 (0.86)	3.78 (0.76)	*-26.53****		5.76 (0.97)	6.05 (0.88)	-3.10**
Older people	2.35 (0.85)	3.77 (0.73)	*-29.98****		4.74 (1.17)	6.14 (0.66)	-8.48***

Note: p<.01**; p<.001***

This increase in overall preparedness for non-substance specialists between T1 and T2[12] was statistically significant in terms of working with adults (t-value = -26.5, p<.001) and with older people (t-value = -29.9, p<.001) after the training programme.

Turning to the responses of substance specialists it is clear that their T1 ratings for work with both adults and older people were substantially higher than those of non-substance specialists. Nevertheless, it is interesting to note that, at baseline, the average score for overall preparedness for working with older people with alcohol problems (mean = 4.74, s.d. =1.17) was lower than preparedness when working with adults in general (mean = 5.76, s.d.

working with problematic alcohol use amongst adults in general and older people in particular.

[11] Substance specialist sample were required to specify whether they felt '1=not at all prepared', '2=poorly prepared', '3=somewhat prepared', '4=adequately prepared', '5=well prepared', '6=very well prepared' or '7=extremely well prepared' by their qualifying or professional training when working with service users.

= 0.97). This demonstrates that while, on average, the substance specialists felt less 'well prepared' to work with older users than adults with alcohol problems prior to the training, this differential was not present after the training. Further, Table 10.5 also illustrates, that substance specialists report themselves to be better prepared by the training programme to work with both adults in general (t-value = -3.1, p<.01) and older people in particular (t-value = -8.5, p<.001).

The key findings in terms of overall preparedness are:

- The average scores of respondents in the non-substance specialist group suggest that prior to the TOML training most felt that they were either 'not well prepared' or 'poorly prepared' when working with adults and older people with problematic alcohol use. However, average scores showed a statistically significant increase following the training indicating that many felt better prepared.

- While most of the substance specialists felt well prepared when working with adults and older people affected by alcohol use, their average scores still increased significantly after the TOML training, especially in terms of preparedness to work with older people with alcohol problems.

- Results from comparative tests showed the positive changes in the average preparedness score for both samples were statistically significant, which indicates that respondents in both the non-substance specialist and the substance specialist groups considered themselves to be better prepared by the training programme.

10.3.3 Current professional practice across different time points

One of the research questions that the project sought to answer was whether there would be differences in the extent and nature of respondents' practice with older users as a result of attending the training. To capture this (which we have labelled 'current professional practice') both non-substance specialists and substance specialists who attended the TOML training were asked to indicate how often they had:

- Worked with an older person with alcohol problem
- Asked an older person questions relating to alcohol use
- Discussed alcohol use among older people with colleagues
- Conducted joint visit/assessment with an alcohol worker/a specialist older person's alcohol worker
- Contacted alcohol service/specialist older person's alcohol service for advice
- Referred older people to alcohol service/ specialist older person's alcohol service.

These questions were asked at two time points to assess whether there was any change in practice following the training: Time 1, which was before the training and Time 3 which is three months after they attended the training. These questions were not asked at Time 2 because the post-training survey was administered on the same day as the training. The questions were phrased slightly differently for the two groups to reflect their different

perspectives. It is important to recognise that the sample size for the non-specialist group at T1 was 313, but only 51 at T2, thus data for tests of change over time were available for only 51 non-substance specialists, and only T1 data were available for the specialist group thus change over time could not be examined for this group.

Non-substance specialist respondents were asked to indicate whether they '1=never', '2=rarely', '3-occasionally', '4=often' or '5=very often' engaged with an older person or colleague on issues relating to problematic alcohol use. A more detailed 7-point frequency scale was administered among the substance specialist group which ranged from 1 = 'Not in the last 3 months' to 7= 'Daily or almost daily'.

In order to explore changes in practice over time, for each practitioner group these frequency data were divided into two groups. For non-substance specialists scores of 1 or 2 (never or rarely) represent a low level of engagement and scores of 3-5 (occasionally to very often) representing a higher level of engagement. For the substance specialist group, low engagement with older users refers to respondents answering '1=not in the last three months' and higher level of engagement includes all other responses which ranged from 2 to 7.

Table 10.6: Proportion of non-substance specialists and substance specialists who engage with older users

	Non-substance specialists, N=51		*Change in Proportion*		**Substance specialists, N=45**
	Time 1	Time 3			Time 1
Worked with an older person with alcohol problem	34%	45%	+11%	Worked with an older person with alcohol problem	57%
Asked an older person questions relating to alcohol use	24%	45%	+21%	Asked an older person questions relating to alcohol use	64%
Discussed alcohol use among older people with colleagues	36%	53%	+17%	Discussed alcohol use among older people with colleagues	73%
Contacted alcohol service for advice	13%	30%	+17%	Contacted a *specialist older person's alcohol service* for advice	33%
Referred older people to alcohol service	10%	16%	+6%	Referred an older person to *a specialist older person's alcohol service*	23%
Conducted joint visit/assessment with an alcohol worker	2%	12%	+10%	Conducted a joint visit to/joint assessment with *a specialist older person's alcohol worker*	16%

Table 10.6 presents the proportion of non-substance specialist (n=51) who engaged with older users for each individual items at Time 1 and Time 3 and, substance specialist at T1 only. As the baseline, the extent of working with older people and alcohol issues among the

non-substance specialists was quite low, ranging from 2% to 31%. Based on the distribution, at T1 the three items with which non-substance specialist respondents were least engaged when working with older people with problematic alcohol use included:

- Conducting a joint visit/assessment with an alcohol worker for an older person. (2%)
- Referring an older person to an alcohol service. (10%)
- Contacting an alcohol service for advice or information about an older person's drinking. (13%)

The descriptive statistics showed that there was a positive change in the proportion of respondents who reported higher engagement with older users with problematic alcohol use as a result of attending the training. The three items with the largest change in relation to nature of non-specialists' practice with older users are:

- Asking an older person questions relating to alcohol use. (+21%)
- Discussing alcohol use among older people with colleagues. (+17%)
- Contacting an alcohol service for advice or information about an older person's drinking. (+17%)

For substance specialist respondents, the extent of engagement with older users at T1 was higher than that for non-substance specialists, ranging from 16% to 73%. The descriptive statistics in Table 10.6 demonstrated that they were least engaged in three areas of current professional practice at the baseline:

- Conducting a joint visit/assessment with *a specialist alcohol worker* for an older person. (16%)
- Referring an older person to *a specialist older person's alcohol service*. (23%)
- Contacting a *specialist older person's alcohol service* for advice or information about an older person's drinking. (33%)

The key findings in terms of current practice are:

- At baseline, both non-substance specialists and substance specialists experienced low levels of involvement working with older people with problematic alcohol use, especially in making referrals, contacting alcohol specialist and conducting a joint visit or assessment with a specialist alcohol worker.

- Descriptive statistics suggest a positive change in the proportion of non-substance specialist respondents who reported higher engagement with older people affected by problematic alcohol use after attending the training.

10.3.4 Knowledge and attitudes about working with older people with alcohol problems.

Finally, in terms of outcomes, this evaluation sought to explore the extent to which the TOML training programme had changed respondents' knowledge of, and attitudes towards working with older people affected with alcohol issues. This section reports the results of an adapted version of a standardised tool, the Alcohol and Alcohol Perceptions Questionnaire (AAPQ; Cartwright 1980; Galvani, Dance & Hutchinson, 2011). This tool was adapted to

focus on knowledge and attitudes related to working with older people experiencing problematic substance use.

Attitudinal tool

The tool had 22 items relating to working with older people with alcohol problems and their families. A seven-point Likert scale was used to capture responses ranging from strongly agree (scored 1) to strongly disagree (scored 7). Given this scoring method and the phrasing of the items, all the items were reverse coded so that higher scores denoted higher levels of commitment and confidence among respondents. Conversely, the lower the score the lower the levels of respondents' commitment and confidence when working with older people affected with problematic alcohol use. [13]

The instrument measures four aspects of respondents' attitudes towards, and knowledge of, working with older people with problematic alcohol use (see Galvani, Dance & Hutchinson, 2011):

1. **Role Adequacy** (10 items) – Explores respondents' levels of knowledge about working with alcohol use among their service users.
2. **Role Legitimacy** (4 items) - Focuses on practitioners' perceptions of their right to ask questions about alcohol use, as well as related problems including the impact on family members.
3. **Role Engagement** (4 items) - Examines practitioners' levels of interest in working with people using alcohol, their willingness to do so, and whether they gain satisfaction from doing so.
4. **Role Support** (4 items) – Indicates the level of support practitioners perceive they have for their work with alcohol use.

A series of reliability tests (Cronbach's Alpha) and exploratory factor analysis (EFA) were conducted for each of the four aspects of attitudes towards, and knowledge of, working with older people with problematic alcohol use. Results showed that it would be appropriate to combine the responses to the individual items in each of the four areas to produce a single 'attitudinal' score for role adequacy, role support, role legitimacy and role engagement. Reliability tests for all the scales across different time-points indicated high levels of internal consistency with Cronbach alpha values range from 0.85 to 0.97 except for the role engagement scale (α= 0.50 at T1).

The remainder of this section presents the questions relating to the first three of these domains and the findings from the analysis. Role support is discussed separately further down.

[13] Mean scores for each attitudinal statement were calculated for all items in each area. These were then collapsed into three broader categories to indicate levels of perceived confidence in and commitment when responding to older people, or their families, experiencing problematic alcohol use. Higher levels of commitment and confidence were accompanied by higher mean scores (scoring >5), moderate level was indicated by scores >3- 5, and lower level by scores 1-3 (see Galvani and Hughes (2010) for similar approach).

Role adequacy

The role adequacy subscale comprised 10 items (see Table 10.7). This domain assessed the respondents perceived levels of knowledge about alcohol use when working with older people and how satisfied they were with the work they do in relation to alcohol. Items included in the role adequacy subscale were:

1. I feel I know enough about the physical effects of alcohol on older people to carry out my role when working with them.
2. I feel I know enough about the psychological effects of alcohol on older people to carry out my role when working with them.
3. I feel I know enough about the causes of alcohol problems in older people to carry out my role when working with them.
4. I feel I can appropriately advise older people about alcohol and its effects.
5. I feel I have adequate information to support family members of older people with alcohol problems.
6. I feel I know enough about the factors which put older people at risk of developing alcohol problems to carry out my role when working with them.
7. I feel I have a working knowledge of alcohol and its related problems amongst older people.
8. I feel I know how to counsel older people with problematic alcohol use over the long term.
9. On the whole, I am satisfied with the way I work with older people with problematic alcohol use.
10. In general, I feel I can understand older people with problematic alcohol use.

Role legitimacy

The role legitimacy domain comprised four items constructed to indicate respondents' perceptions of their right to ask questions of older people about the extent and potential impact of their alcohol use, including its effect on family members. Items included in the role adequacy subscale were:

1. I feel I have the right to ask older people for any information that is relevant to their alcohol problems.
2. I feel I have the right to ask older people questions about their alcohol use when necessary.
3. I have the right to ask older people with problematic alcohol use about how their relatives may be coping.
4. I feel that older people believe I have the right to ask them questions about their alcohol use when necessary.

Role engagement

The role engagement subscale consisted of four items relating to practitioners' engagement in working with older people using alcohol, and whether they gain satisfaction from doing so. The items were:

1. I am interested in working with, and responding to, family members of older people with alcohol problems.

2. I want to work with older people with alcohol problems.
3. In general, it is rewarding to work with older people with alcohol problems.
4. In general, one can get satisfaction from working with older people with alcohol problems.

The average scores for role adequacy, role legitimacy and role engagement across different time points for each participant group are presented in Table 10.7 (below).

Comparative tests were conducted to determine the extent of change in attitudes of both non-substance specialists and substance specialists between T1 and T2 (before and after the training programme). Results from paired t-tests had indicated that there was no significant difference in mean scores on any of the domains between T2 and T3 (where T3 data were available). Therefore, comparative ANOVA tests across three time points were not conducted.

Changes in average group scores for role adequacy

As expected, at baseline (T1), the mean score for **role adequacy** of the substance specialists was 5.1 (s.d. = 0.8), higher than the mean score of 3.6 (s.d. = 1.1) among those in the non-substance specialist group. While the differential between substance specialists and non-substance specialists persisted following the training, tests of change over time revealed statistically significant increases in the levels of role adequacy among both groups of respondents between T1 and T2. These findings suggest that after receiving the training, all respondents felt more knowledgeable and more adequately prepared for working with older people with problematic alcohol use than had been the case previously.

Changes in average group scores for role legitimacy

Turning to consider **role legitimacy** as shown in Table 10.7, the average scores for this domain were 4.2 (s.d.=1.1) for non-substance specialist respondents at baseline and 5.5 for substance specialists. These values increased significantly after the training to 4.9 (s.d.=1.1) for non-substance specialists (t=-15.3, p<.001) and 6.02 (t-value=-5.3, p<.001) for substance specialists. The significant positive changes in role legitimacy score across time suggested that more respondents in both groups felt more confident about their role in questioning their older service users about their alcohol use.

Table 10.7 Mean scores for knowledge and attitude scales for non-substance specialists and substance specialists at T1 and T2

	Non-substance specialists, Mean (SD)		*T-value (T1-T2)*	**Substance specialists,** Mean (SD)		T-value (T1-T2)
Attitudes toward alcohol use	Time 1 (T1)	Time 2 (T2)		Time 1 (T1)	Time 2 (T2)	
Role adequacy	3.69 (1.15)	5.05 (0.94)	*-24.33****	5.16 (0.88)	6.03 (1.93)	-4.06***
Role legitimacy	4.20 (1.19)	4.96 (1.14)	*-15.36****	5.46 (0.96)	6.02 (1.37)	-5.36***
Role engagement	4.45 (1.27)	4.79 (1.10)	*-5.72****	5.56 (1.16)	6.01 (0.99)	-5.49***

Role support	-	-	-	3.25 (1.03)	-	-

Note: p<.05*; p<.01**; p<.001***

Changes in average group scores for role engagement

The average score for **role engagement** at T1 among non-substance specialists at T1 was 4.4 (s.d.=1.2). After the training (T2), the reported mean score was higher at 4.9 (s.d.=1. 0). For substance specialists the average score at T1 was 5.5 and this had increased to 6 at T2. Again, for both sample groups the increase in average scores was statistically significant (t=5.72 and 5.49 for non-substance specialists and substance specialists respectively).

Taken together, it can be seen that the training did have a positive impact for both groups of participants although the increases in average score are relatively small, particularly in relation to role legitimacy and role engagement for non-substance specialists. Nevertheless, in relation to non-substance specialists in particular the average scores had been close to '4' which indicates a 'neither agree or disagree' response. After the training the averages were closer to '5', indicating that after the training programme, respondents from the non-substance specialist group were more likely to agree that they felt sufficiently knowledgeable, more legitimate, and more prepared, to engage in work with older people affected by alcohol. Similarly, for substance specialists, average scores of close to 5 at baseline across all domains were seen to increase to averages in the region of 6.

Changes in attitudes by category

A clearer indication of movement between T1 and T2 can be seen if responses for each participant are categorised into low, moderate and high scores on each domain.[14] The results of this analysis are presented in figures 10.5 to 10.10.

This approach demonstrates very clearly how responses were distributed over time and between respondent groups. Further, it is possible to include the T3 data for the non-substance specialists.

At baseline, the responses to role adequacy items revealed that a majority of respondents in the non-specialist group felt moderately confident when working with alcohol issues. However, nearly a quarter indicated low confidence in their knowledge and practice with older people who have problematic alcohol use and only a minority (7%) felt highly confident with their knowledge and role when working with older people's alcohol issues.

Based on the frequencies at Time 2 and Time 3 (see Figure 10.5), it was clearly shown that after the training programme, there was a greater perception of role adequacy among the respondents. Almost 40% of the respondents reported higher levels of role adequacy when working with older people with problematic alcohol use immediately after the training

[14] Mean scores for each attitudinal domain were calculated for each participant. These were then collapsed into three broader categories of perceived confidence in responding to older people experiencing problematic alcohol use. The threshold used were 'high confidence' = mean domain score >5), 'moderate confidence' for mean domain score >3 but <6, and 'lower confidence' for mean domain scores between 1-3 (see Galvani and Hughes (2010) for similar approach).

programme (39%) and this proportion was similar three months later (37%).

Similarly, at baseline, just 41% of substance specialists felt confident about their role with older service users. After the training, this percentage can be seen to increase to 80% (see Figure 10.6).

Figure 10.5: Attitude towards role adequacy across three time-point for non-substance specialists

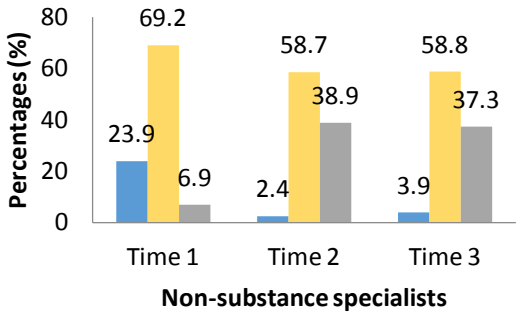
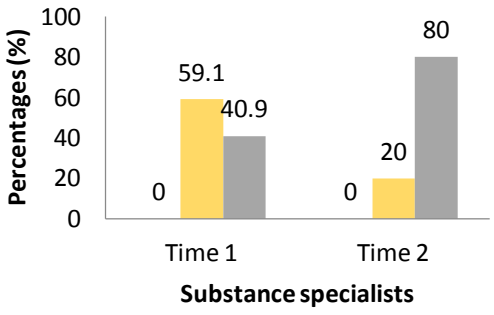


Figure 10.6: Attitudes towards role adequacy across three time-points for substance specialists



In relation to **role legitimacy,** the scores at baseline for the non-substance specialist group (Figure 10.7) show that two thirds or 68% of respondents expressed moderate confidence that they had a right to explore alcohol use with clients; only 16% reported high levels of confidence. However, after the training programme (T2), the proportion of respondents in the non-substance specialist group who reported high levels of confidence increased to 35%, with 29.4% retaining high confidence at the 3-months follow-up (T3).

For the substance specialist sample (Figure 10.8) the proportion of respondents who reported high confidence on role legitimacy items increased from 59.1% at baseline to 77.8% after the training; while those with low confidence has reduced from 40.9% prior to the training to 22.2% after they attended the training.

Figure 10.7: Attitude towards role legitimacy across three time-points for non-substance specialists

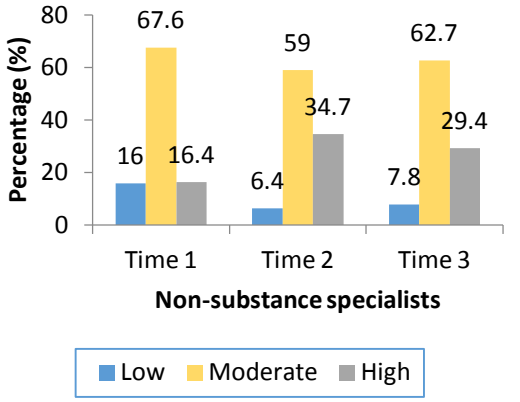
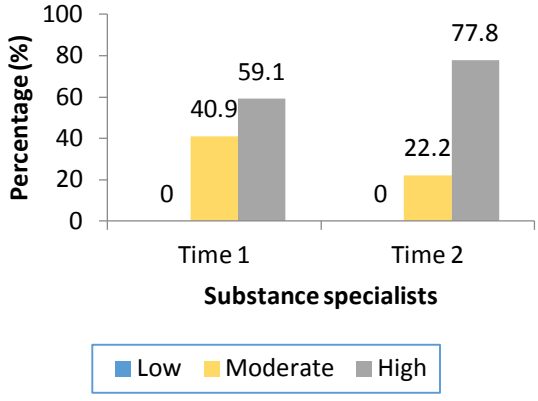


Figure 10.8: Attitude towards role legitimacy across three time-points for substance specialists



And finally, turning to **role engagement**, a large proportion of the non-substance specialists reported moderate levels of role engagement across the three different time points, 74%, 63% and 67% respectively (see Figure 10.9). However, although there was a reduction between T1 and T2 in the percentage of people scoring in the low range, there were more non-substance specialists reporting high levels of role engagement at Time 2 (32%). Again this increase, while modest, largely continued at T3.

Figure 10.9: Attitude towards role engagement across three time-points for non-substance specialists

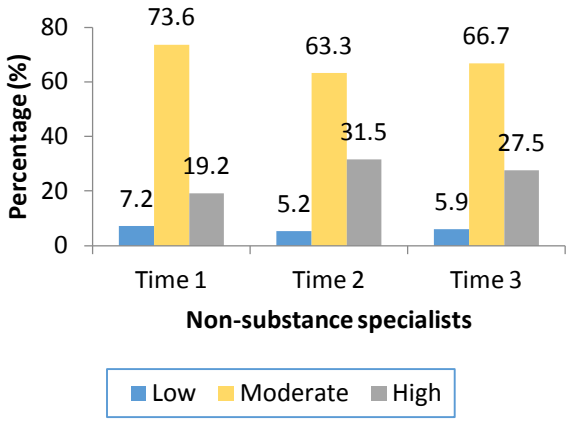
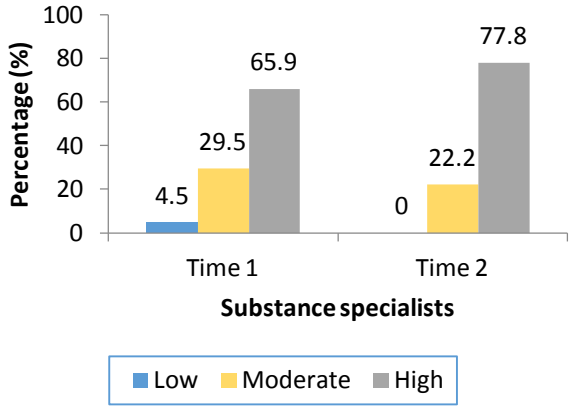


Figure 10.10: Attitude towards role engagement across three time-points for substance specialists



In thinking about the substance specialist respondents (see Figure 10.10), results show that the proportion of respondents reporting high levels of role engagement increased from 66% at baseline (T1) to 78% after the training; while those with low confidence reduced to zero from 4.5% at Time 1 or baseline.

For both role legitimacy and role engagement there was a slight drop in the percentage of non-substance specialists in the high grouping between T2 and T3. In terms of thinking about why this might be, it is important to bear in mind that the numbers represented at T3 were much smaller than earlier time points and the representation of practice groups were different. Also, as discussed in section 10.3.3 there was little evidence of increased encounters with older service users between T2 and T3. It is possible therefore that lack of practice opportunity did not reinforce changed attitudes.

Role support

'Role support', while part of the AAPPQ is conceived slightly differently to the other domains. It is not about attitudes or perceived levels of competence, rather it is about the support a practitioner feels is available to them in their work with the client group. This element of the questionnaire comprised four items, the responses to which indicate the level of perceived support respondents had for their work with older people with alcohol problems at the time of the study. This subscale was only administered at the baseline (Time 1) and 3-months follow-up (Time 3). Because of the low return rate at T3, data at both time points are only available for 51 non-substance specialists. The items included in the subscale were:

1. If I felt the need I could easily find someone at work who would be able to help me formulate the best way of working with an older alcohol user.
2. If I felt the need when working with older alcohol users, I could easily find someone with whom I could discuss any personal difficulties that I might encounter.
3. If I felt the need when working with older alcohol users I could easily find someone at work who would help me clarify my professional responsibilities.
4. I feel adequately supported within my service to work with family members of older alcohol users.

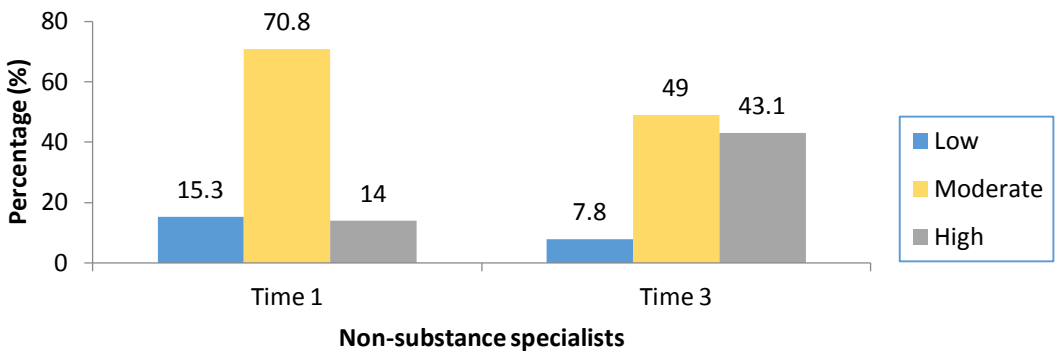
As shown in Table 10.8, the average score for role support among respondents in the non-substance specialist group was 4.3 (s.d.=1.0) before the training and this figure increased to 5.0 (s.d. 1.1) 3 months after the training, t-value =-4.0, p<.001. The significant positive change in role support between Time 1 and Time 3 suggested respondents in the non-substance specialist group were more confident that they had, or could access, adequate levels of support during their work with older people affected by alcohol and their family members after attending the training. For the substance specialist sample, results at the baseline reveal a role support mean score of 3.2 (s.d.=1.0) which is lower than those in the non-substance specialist group (mean=4.3 s.d.=1.0), indicating a perceived lack of appropriate support among the substance specialists. No comparative test across time points was conducted for the substance specialist group due to insufficient data at the follow-up time-point (Time 3).

Table 10.8 Change in average scores for role support T1 to T3

	Non-substance specialists Mean (SD)		*T-value (T1-T3)*	**Substance specialists** Mean (SD)		T-Value (T1-T3)
Attitudes toward alcohol use	Time 1 (T1)	Time 3 (T3)		Time 1 (T1)	Time 3 (T3)	
Role support	4.31 (1.03	5.02 (1.19)	*-4.09****	3.25 (1.03)	-	-

As illustrated in Figure 10.11 below, grouping the average scores for role support showed that at baseline 70% of respondents in the non-substance specialist group felt moderately confident about the availability of support for their work with older people with problematic alcohol use. A small proportion (14%) reported high levels of confidence in this aspect of work. However, at the follow up stage (Time 3), the proportion reporting high confidence in the availability of support at work increased significantly to 43%, and only a minority of 8% had little confidence in finding the support they needed for working with alcohol users and their family members.

Figure 10.11: Attitude towards role support across two time-points for non-substance specialists



Key findings on changes in knowledge and attitudes

The key findings on the extent to which the TOML training programme has changed respondent's knowledge and attitudes towards working with older people affected by alcohol problems are as follows:

- The results revealed a greater sense of commitment and confidence toward working with older people affected by problematic alcohol use among non-substance specialists and substance specialists following the training and these positive changes remained consistent after 3 months. The change over time for substance specialists was not examined due to the small number responding at the follow-up.
- Both non-substance specialist and substance specialist respondents perceived themselves to be more adequately prepared for working with older people with problematic alcohol use after the training.
- In addition, after the training and at the 3 months' follow-up point, non-substance specialists and substance specialists reported a greater sense of role legitimacy which enabled them to be more confident about their role in questioning service users about alcohol use.
- In terms of role engagement, after attending the training programme, the respondents from both groups also expressed greater interest in, and commitment to, working with older people with problematic alcohol use.
- As for role support, non-substance specialists were found to be more confident that they had, or could access, adequate levels of support for their work with older people with alcohol problems after attending the training. No comparative test for role support was conducted among the substance specialist group due to the lack of data at the 3 months' follow-up point (T3).

10.3.5 Relationships between respondents' overall preparedness, attitudes and current practice

One of the core aims of the evaluation was to explore how respondents' perceptions of preparedness, attitudes and current practice have changed after attending the TOML training. In particular, this section presents findings on the factors which were related to

participants' current practice[15] in working with older people affected with problematic alcohol use.

To achieve this Pearson Product Moment Correlation tests (r) were used to examine the strength of the relationships between the level of overall preparedness and various aspects of attitudes towards working with people affected by alcohol and how they relate to practice among respondents across different time-points.

For respondents in the non-substance specialist group, prior to TOML training (Time 1), their current practice in working with older people with alcohol problems was related to a number of factors:

- the duration of prior training on alcohol for adults and older people (r=0.27 and 0.36 respectively),
- whether or not they were social work students (r=0.14),
- overall preparedness scores (r values from .34-.46) and
- all four aspects of attitudes towards and knowledge of, working with older people with problematic alcohol use (r values from .17 (role support) to .49 (role adequacy at T1)).

However, a number of these correlations were weak suggesting that they explained little of the variance in current practice[16]. For result interpretation, r values 0.30 or above are described as moderate correlations; while r values below 0.30 were considered as weak relationship between factors (Evans, 1996). It can be interpreted that most of the significant relationships for the non-substance specialist sample were at moderate strength except for duration of prior training on alcohol for adults (Time 1), role support (Time 1) and not being social work students.

Based on the data at Time 3, non-substance specialists who felt more prepared for working with adults in general, and older people in particular, tended to report that they worked more frequently with an older person and colleagues on issues related to alcohol use (r values .31 and .35 respectively). It was also clear that there were positive associations between current practice with alcohol service users at T3 and higher T3 levels of role adequacy, legitimacy, engagement and support (r values = .47, .40, .45 and .31 respectively).

Due to the lack of responses from the substance specialist sample at T3, results for correlational analysis were only available for current professional practice at T1.

[15] For the correlational analysis, respondents' scores for each 'current practice' item were summed, and then divided by the number of items to produce an overall 'score' for current practice. Reliability tests of this scale for each respondent group and across different time points showed high levels of internal consistency with Cronbach alpha values ranging from 0.88 to 0.91.

[16] R-values can range from -1 to 1, where -1 or 1 indicates perfect correlation and a value of 0 indicates no relationship between variables, thus, the closer the value of r to 1 (or -1) the stronger the relationship between two variables. The positive (+) and negative (-) signs denote whether the direction of the relationship is positive or inverse.

10.4 Discussion

This chapter has presented the findings from self-completion questionnaires to consider the impact of a short training programme focused on working with older people affected by alcohol problems. Questionnaires were completed by programme participants before the training (n=382), after the training (n=364) and then again three months later (n=53). One group of participants comprised people working in a specialist addiction service ('substance specialists' n=51) other 'non-specialist' participants (n=313) were drawn from a range of human services. Sample sizes at Time 1 and Time 2 were substantial but response at Time 3 was poor which limited confidence in exploring longer term impact.

The major areas explored by the questionnaire were prior training and preparedness to work with alcohol issues, 'current professional practice' (which was a measure of the extent to which participants actually worked with service users with alcohol problems), and knowledge about, and attitudes towards, working with this client group. Analysis addressed change in these measures over time, and relationships between them.

Of the non-specialist group just over half had received prior training in working with adults with alcohol problems; for most this was just a half day or a day but a minority of participants (10%) had received between two and five days. In relation to working with older people specifically these proportions dropped and only 27% had received any training with only about 4% receiving more than a day. Among the substance specialists 43% had received training and indeed nearly half of these had received two days or more.

Preparedness to work with both adults and with older service users who had alcohol problems was explored using an eight items checklist. As might be expected substance specialists reported feeling better prepared than did non-substance specialists for working with both adults and older people with alcohol issues. However, at time 1 both participants reported feeling less prepared for working with older clients than they were for working with adults in general. At Time 2 there were statistically significant increases in preparedness scores for both participant groups with both groups of service users.

Because of the nature of the questions about current practice and the fact that the training was completed within one day, these items were only explored at Time 1 and Time 3. The poor response at Time 3 meant that the sample size for non-substance specialists was reduced to 51 for comparative analysis and no comparative analysis could be conducted for substance specialists at all. At Time 1, for both participant groups the extent of working with older people and alcohol issues was quite low. Time 3 responses for the non-substance specialists showed some increase in the proportion of participants who engaged with older users after attending the training but the increase was modest at 20% or lower. Two factors complicate interpretation of this finding: a) The non-substance specialist group comprised a diverse range of professional disciplines whose roles may bring them into contact with older service users in different contexts and b) Time 3 data were only available for a sub-sample of the original non-specialist group and numbers were relatively small limiting the ability to explore experience for smaller sub-groups.

Knowledge about, and attitudes towards, working with older people who have alcohol problems was explored using an adapted version of an established tool called the AAPPQ.

The tool had 22 questions focused on working with older people and alcohol problems. Participants' responses to these questions allowed for individual scores to be calculated on each of four domains: Role Adequacy (feeling that one **knows how** to work with service users), Role Legitimacy (feeling that one **has the right** to ask questions etc); Role Engagement (feeling that one **wants to work** with service users) and Role Support (feeling confident in being able to **source support** in working with service users). The scores for substance specialists were higher than those for non-substance specialists at both Time 1 and Time 2 but for both participant groups there were statistically significant increases in scores between these two time points. Particularly marked were the increases for non-substance specialists in their perceptions of role adequacy and role legitimacy indicating a direct and significant impact of the training workshops. The increase in role engagement scores for this group was statistically significant but modest suggesting that perhaps engagement is something that needs experience. For better data visualisation, these domain scores were also assessed using a categorical approach. This revealed that while there was a small decrease in legitimacy and the engagement domains, the proportion of non-specialist participants reporting positive attitudes was largely maintained over the three months following training. Again it is possible that lack of practice opportunity meant that attitudes were not reinforced, or it may be that there was some bias in the composition of the group responding at Time 3.

Role support was measured at Time 1 and Time 3 only. Interestingly substance specialists had lower scores than non-substance specialists at Time 1. There was a significant increase in score at Time 3 for non-substance specialists suggesting they had more confidence that they could access support as needed. No Time 3 data were available for substance specialists.

The exploration of factors associated with current practice at Time 1 revealed that this was associated with the extent of prior training participants had received, whether they were social work students, how prepared they felt for working with this service user group and all four domains of the knowledge and attitudes scale. Practice at time 3 was associated with a similar range of factors but it was also clear that those who felt more prepared by the TOML training tended to report more frequent working with older clients and alcohol issues. However, since the test used (Pearson correlation) was a measure of association it is not appropriate to infer that the training led to increased working, indeed it may be that those who were working with this client group got more out of the training.

10.5 Summary and recommendations

In summary, this analysis has demonstrated that the TOML training improved preparedness for and attitudes towards working with older people with alcohol problems among both substance specialists and non-substance specialists although there was evidence of little change in practice with this service user group. However, the ability to explore longer-term change in practice and whether attitude changes were maintained over time was limited by a poor response at follow-up. The examination of associations between current practice, preparedness and attitudes showed that these measures were all inter-related. The diverse range of professional disciplines (health and social care employees, mental health service staff, police officers, student social workers and fire services) among the non-substance

specialist group may have implications for changes over time in their attitudes and current practice after the TOML training and, thus warrants further exploration based on professional disciplines of participants.

Recommendations

1. The training was received well and should be continued, however consideration could be given to booster sessions or organisational support to ensure change in practice.

Chapter 11: Economic evaluation – The Costs and Benefits of the Time of my Life Project

Author: Professor Kevin Albertson – Professor of Economics, Manchester Metropolitan University

Key messages

- A break-even analysis was conducted. This is a form of economic evaluation which assesses how much change TOML would need to make, in monetary terms, in order for the costs of the project to be covered.
- The total costs of TOML project are approximately £495,141.00 per year (including volunteers' time), or £340,040 (excluding volunteers' time).
- The annual social savings are estimated to be £272,157.00.
- TOML will break-even providing people completing the programme maintain their target level of alcohol intake for 22 months (or 15 months if volunteer time is not included in the costs). However, these data are not available.
- There is a need for improved data collection in order to conduct a more definitive economic evaluation, for example, a cost/benefit or Social Return on Investment analysis

11.1 Introduction

This chapter provides an estimate of the potential benefits and costs of the Time of my Life (TOML) programme. We briefly set out the principles of economic evaluation, and in particular, the approach we follow here. We go on to discuss the private and social costs of alcohol abuse in general before turning ourselves to the TOML programme. The costs of TOML are compared to the potential benefits of engagement with the programme. The likelihood of particular outcomes amongst the client group is determined through an analysis of client data, and this is combined with potential cost savings to determine whether or not TOML is likely to "break-even", in the sense that the expected social and private cost savings are greater than the intervention cost, given the available data.

11.2 Evaluation – a brief overview

According to Drummond *et al*. (2005:4) an economic evaluation of a health intervention involves "the comparative analysis of alternative courses of action in terms of both their costs and consequences". In general, attempts to address these issues fall into one of four forms:

- Cost analysis: This is a partial form of economic evaluation that deals only with the costs of an intervention;
- Cost-effectiveness analysis: A form of evaluation where the consequences of an intervention are measured in the most appropriate natural effects physical units (that is to say, not necessarily in monetary terms). As the desired outputs of the intervention are not monetised the results are expressed as a cost-effectiveness ratio, for example £1,000 per client or intervention delivered.

- Break-even analysis: A form of evaluation in which the costs and potential benefits of the intervention are determined in monetary terms, but the scale of the benefits are not able to be estimated – perhaps because of lack of appropriate data. In this case, the results of the evaluation address how a great a change is required as a result of the intervention so that we may be confident of covering costs.
- Cost/Benefit Analysis: As with a break-even analysis, this is a form of evaluation where the consequences are valued in monetary terms. In this case, the scale of the benefits may be estimated. We can, therefore, conclude by how much benefits exceed costs (or otherwise).

Where data is available, a form of cost/benefit analysis can be utilised which is particularly suited to third sector organisations; the Social Return on Investment (SROI) approach (Arvidson *et al*., 2010). An SROI analysis augments an economic cost/benefit analysis with social and environmental outcomes. Potentially this is the broadest form of evaluation method; however, difficulties in capturing and measuring wider consequences of an intervention mean that, in reality, its scope can be limited.

In the following, we adopt the approach of break-even analysis, for reasons of availability of data.

11.3 The incidence of the problematic use of alcohol

In England, in 2013/14, around nine-million adults drink at levels that pose some risk to their health with 2·2 million drinking at higher-risk of harm (Public Health England, 2014a). The incidence of alcohol abuse is relatively more serious amongst the more elderly of the nation with surveys indicating that 13% of people over 65 had drunk alcohol every day during the previous week, compared with just 1% of 16-25 year olds and 9% of 25-64 year olds (Giles 2016). Assuming this data is representative of England, we can estimate the number of people in England who drank alcohol every day in the preceding week using demographic data.

We should, or course, be wary of assuming that a person who drinks alcohol every day is necessary a problem drinker. A person who binges three to four times a week may be more likely to have an alcohol problem than an individual who restricts themselves to a small glass of sherry every day. In general, however, there is an increased likelihood of having a drinking problem amongst those who drink every day. Assuming the relationship between daily drinking and hazardous drinking does not differ amongst age groups, we estimate problematic drinkers can be broken down by the age categories in Table 12.1 below:

Table 11.1: Incidence of alcohol misuse in England

Age	Population (England)	Drink alcohol every day	Some risk to health	Higher risk of harm
0-14	9,372,010	-		
15-24	6,935,586	69,356	167,832	41,026
25-64	28,044,331	2,523,990	6,107,717	1,492,997
65+	8,660,529	1,125,869	2,724,451	665,977

11.4 The cost of alcohol abuse

The physical, psychological and social harms of excessive alcohol use represent an important public health problem and are associated with considerable social costs. The annual cost of alcohol-related harm has been estimated (Public Health England, 2014b) as: Crime in England: £11bn, Lost productivity in UK: £7bn, NHS in England: £3·5bn.

It is a long established observation that, for a cohort of people, the rate of perpetration of criminal behaviour declines strongly with age; relatively very few crimes are committed by those over 50 (Hirschi and Gottfredson1983). Given the age of the clients of TOML, society is unlikely to realise substantial (or perhaps any) savings in foregone crime resulting from the intervention. The focus of our analysis will therefore be on the savings which might be expected, following a reduction in alcohol use, in the areas of: workplace productivity; health care; eviction/homelessness and excess morbidity (the increase in mortality suffered by problematic drinkers).

11.4.1 Productivity loss

The total cost of lost productivity in the UK due to alcohol abuse is £7bn per annum as above. Assuming all regions of the UK suffer from this proportionally, the cost to England is £5·9bn. If we further assume (as seems likely) that these productivity costs accrue to those 6,275,549 people of working age in England who drink to the point where they are at risk of harming their health, it follows that the average cost to productivity of a working age person drinking at a harmful level is estimated to be £936 per annum. Note that this is very much a lower bound figure. It might be, for example, it is only those of working age who drink alcohol every day, of which there are 2,593,346 in England, who accrue productivity costs. In which case the productivity loss per person would be £3827 per annum.

11.4.2 Cost of unplanned NHS admissions and A&E attendance

Up to 40% of A&E presentations are alcohol related – up to 70% on a Saturday night (National Addiction Centre, undated). The presenting conditions include injuries arising from road traffic accidents, accidents in the home and assault, as well as alcohol poisoning/intoxication and withdrawal symptoms. A single visit to A&E costs an estimated £124 (Choose Well Manchester, online)[17] just to be seen; the total cost of the 5·3 million emergency admissions in England for 2012-2013 was £12·5bn, which allows us to calculate the average cost of an emergency admission is approximately £2300 per person in 2012/2013 prices (National Audit Office 2013); £2400 in 2014/2015.

11.4.3 Eviction – housing

If unsupported, there is a risk that people might lose their home through alcohol misuse (Giles, *ibid*.). The presenting issues might include failure to maintain a property, keep up with the rent, or deteriorating relationships with neighbours. The cost of an eviction, in general, has been estimated to be in the region of £8,000 per case.

[17] See also A&E Category 1 investigation with category 1-2 treatment 77 (Annex_5A_National_Prices.xlsx)

11.4.4 Impact on mortality

We may also consider the reduced longevity which results from drinking; that is to say, the increased risk of passing away in any given year which is associated with alcohol misuse. These increased health risks are set out in Table 12.2 below. Associated with the increased risk of death is the value of that risk, for which we use the Quality-adjusted Life Year, QALY. QALYs provide a common currency to monetise the benefits gained or lost from a variety of health interventions and represent a measure of a person's length of life weighted by a valuation of their health-related quality of life.

The increased likelihood of death per year broken down by age and gender and the associated costs (£ per year) borne by the individual (assuming a typical Quality-adjusted Life Year, QALY (NICE, online), is valued at £30,000 (Based on Table 3 in Barbosa et al 2010):

Table 11.2: Excess health risk and associated cost (£ per year) to the individual

Age	Harmful Drinking		Ex-Harmful		Excess Risk		Cost	
	Males	Females	Males	Females	Males	Females	Males	Females
15-29	1·01%	0·25%	0·25%	0·07%	0·76%	0·18%	228	54
30-44	1·94%	0·79%	0·63%	0·35%	1·31%	0·44%	393	132
45-59	5·04%	2·76%	2·50%	1·55%	2·54%	1·21%	762	363
60-69	10·46%	5·92%	7·82%	4·77%	2·64%	1·15%	792	345
70-79	26·65%	18·76%	23·16%	16·94%	3·49%	1·82%	1047	546
>80	65·95%	70·24%	61·86%	67·10%	4·09%	3·14%	1227	942

11.5 Cost and Benefit Calculation

11.5.1 Costs of TOML

TOML is a three year project which started operating in April 2014. The revised budget, agreed during 15/16 is as follows:

Table 11.3: Costs of TOML

Direct Costs	Year 1 (2014/15) Actual spend	Year 2 (2015/16) Planned budget	Year 3 (2016/17) Planned budget	Total (£)
Salaries	205,226	227,853	233,188	666,267
Recruitment	3,722	4,080	4,162	11,964
Training	7,160	16,646	16,646	40,452
Travel & other expenses	10,021	38,394	39,096	87,511
Accommodation & utilities	18,903	23,990	24,470	67,363
Marketing & communications	3,832	5,100	5,202	14,134
Monitoring & evaluation	33,000	0	0	33,000
Management	54,423	49,694	50,688	154,805
Laptops	1,404	0	0	1,404
Total	337,691	365,757	373,452	
Total in 2014/15 prices [18]	337,691	357,884	357,547	1,053,121

Costs (in kind)	Year 1 Planned budget	Year 2 Planned budget	Year 3 Planned budget	Total (£)
Staff Training	1,900	1,938	1,977	5,815
Volunteer Training	3,640	2,652	2,652	8,944
Older Volunteer Time	88,128	89,891	91,688	269,707
Future Professional Volunteer Time	33,048	33,709	34,383	101,140
Other Professionals' Local Delivery Grant Time	16,200	16,524	16,854	49,578
Time of My Life Forum Meetings	2,400	2,448	2,497	7,345
Activity Group Room Hire (50%)	9,360	11,750	11,985	33,095
Total	154,676	158,912	162,036	
Total in 2014/15 prices	154,676	155,491	155,135	465,302

In summary, the accounting (and total, in brackets[19]) costs of the TOML project over three years, *excluding evaluation costs*, are £1,053,121 – £33,000 = £1,020,121 (£1,485,424) in 2014/2015 prices. This is approximately equivalent to £340,040 (£495,141) per year.

11.5.2 Client Group

In the following section, we restrict our analysis to the 413 people who were referred to TOML from 1st June 2014 to 31st May 2015, which is the first full-year of TOML's operation.

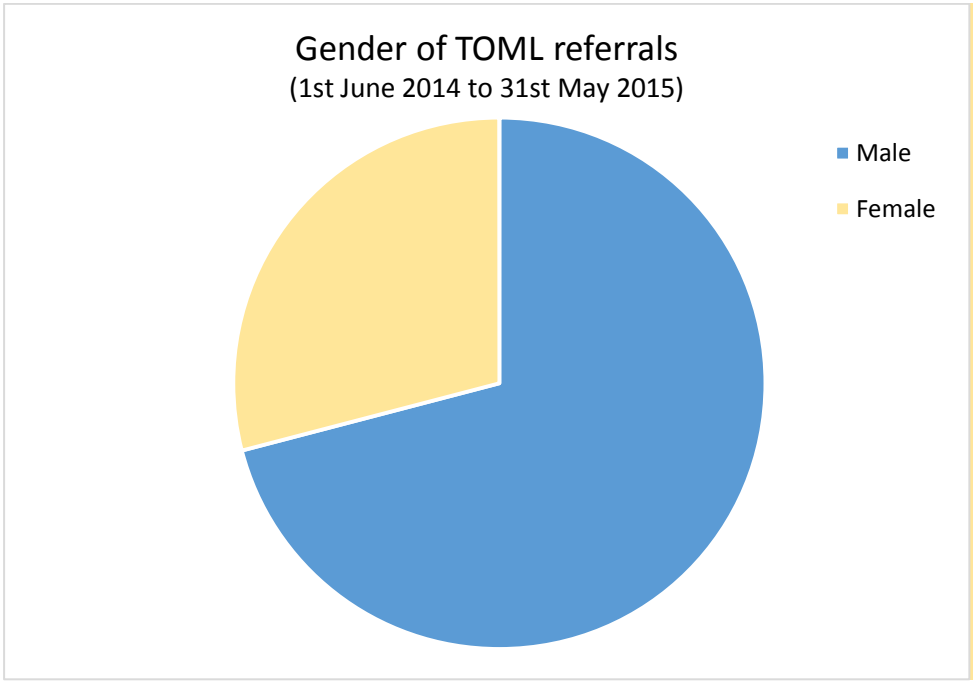
[18] Using a discount rate of 2·2%, as per HM Government (2014) Using a discount rate of 2·2%, as per HM Government (2014)

[19] The distinction is that total costs will include the value of goods and services given in kind – for example, volunteer time.

Of these 413 people, 59 made no contact with TOML. Assuming this is a typical year, the average accounting cost per person was £823 (average total cost £1199) in 2014/15 prices. If, however, we restrict our consideration to those who actually contacted TOML, the accounting cost per person is £1108 (average total cost £1613).

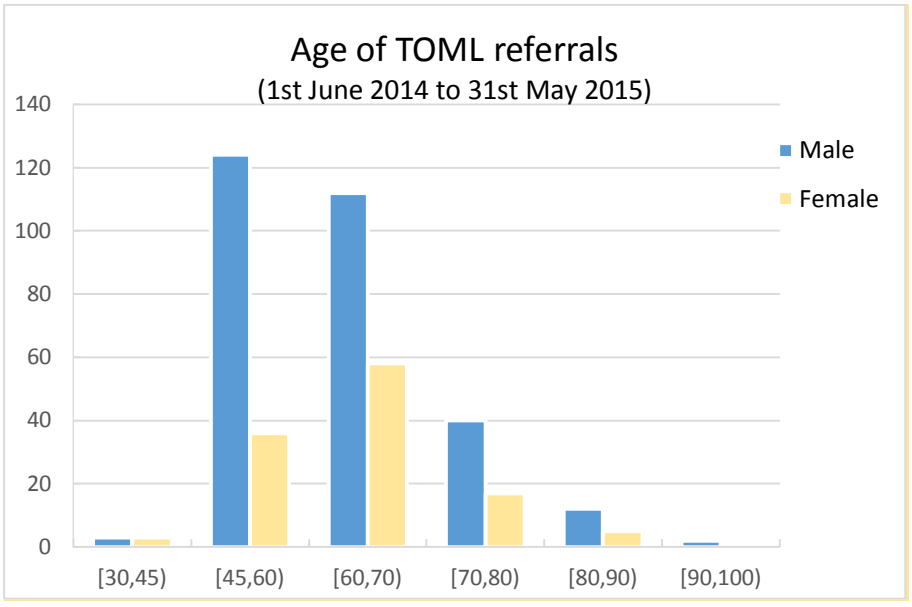
Of this client group, approximately two thirds were male; of those where ethnicity is recorded, the majority, 84%, describe themselves as "White British".

Figure 11.1: Gender of TOML referrals



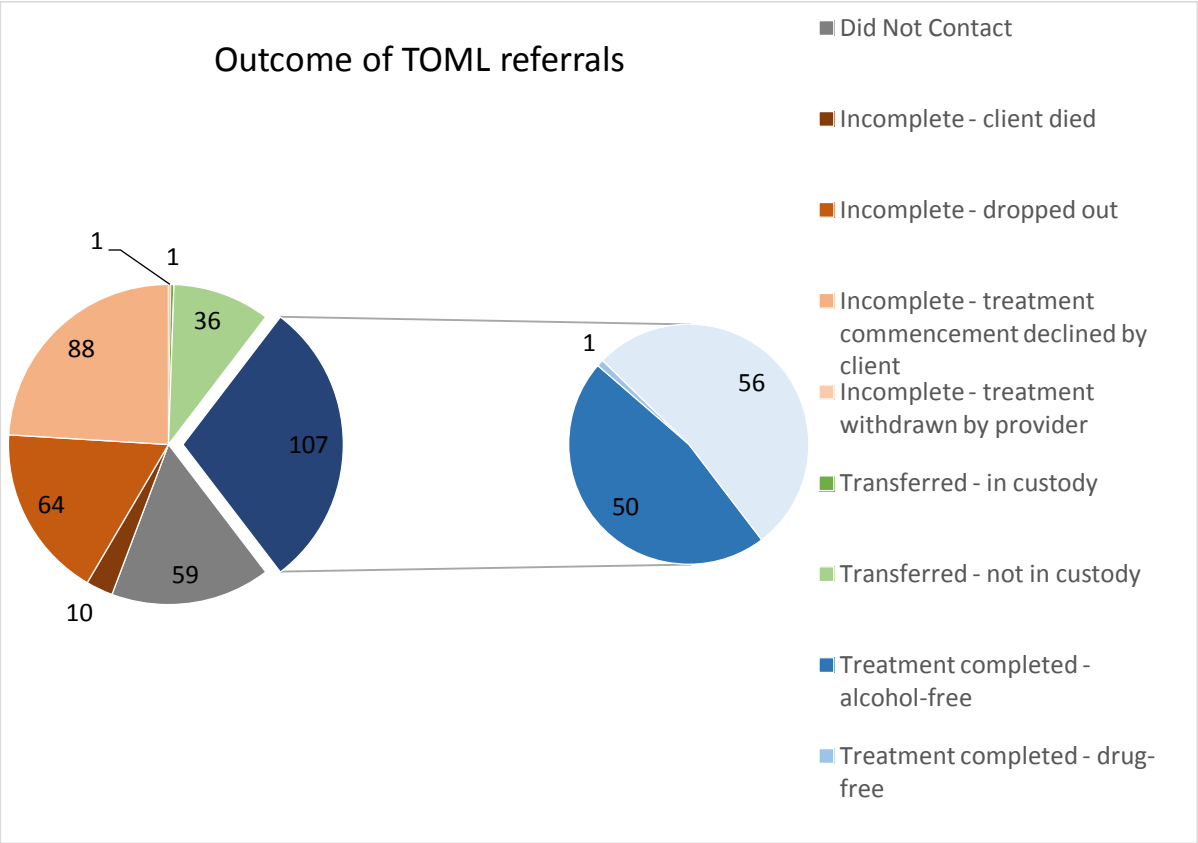
The average age of the referred group was 62 years – 61 for males and 63 for females.

Figure 11.2: Age of TOML referrals



Of these 413 people, 366 were discharged as at December 2015. Of these, 59 (16%) did not contact TOML, and a further 88 (24%) declined treatment. In total 107 (26% of total referrals) completed, which represents 30% of those who contacted TOML.

Figure 11.3: Outcome of TOML referrals



There is some, but not significant, evidence that the likelihood of completing treatment is influenced by gender and age – males are less likely, but not statistically significantly less likely, to complete than females.

11.6 Benefits of TOML

In all cases, no control group is available, neither do we have any follow-up evidence. Hence, for pragmatic reasons, we must make a number of assumptions:

1. Where clients did not complete TOML, there has been no change in their patterns of drinking;
2. Where clients did complete TOML, we assume that the change in their patterns of drinking are attributable to TOML

As we have no follow-up evidence, which is to say that it is not clear if the change in relation to alcohol is long-term, we base our estimated break-even point on how long the benefits arising from completing TOML can be maintained. In other words, for how long must a client

of TOML desist for the estimated benefits to outweigh the costs of treatment. The (lower bound) cost savings arising from TOML are estimated to be £2,544 per person who completes the programme per year. This is made up of the costs shown below.

11.6.1 Productivity loss

We have argued the average cost to productivity of a working age person drinking at a harmful level is at least £936. Of those 107 people who were referred to TOML in the year June 2014 to May 2015, and completed, 58% were of working age. It follows, assuming no change in behaviour of those who did not complete TOML, and assuming, having completed TOML completers caused no productivity problems for a year, the saving is £58,032.

11.6.2 Cost of unplanned NHS admissions and A&E attendance

We have no data available regarding A&E visits of the TOML client group; we therefore focus on hospital admissions data. Of those who completed TOML, in the year before they engaged with the programme, there were 69 alcohol-related hospital admissions. Assuming that those who completed TOML will have no alcohol-related admissions in the year following, this amounts to a saving of £158,700. Note that there might also be A&E savings; hence this is likely to be a lower-bound figure.

11.6.3 Eviction – housing

Currently, we do not have data on the risk of eviction of TOML clients. Therefore, it is not possible to factor this cost into the break-even analysis.

11.6.4 Impact on mortality

The costs associated with the impact of alcohol misuse are on mortality are given above in Table 12.2. Given the age and gender profile of those who completed TOML, the gain in longevity is worth a total of £55,425 per year.

11.7 Break-even Point

The total annual social saving from those individuals who were referred in the year June 2014 to May 2015 and completed TOML is estimated to be £272,157. As the annual cost of TOML is £340,040 (£495,141 including volunteers' time), we see that TOML will break-even if those completing the programme maintain their target level of alcohol intake for at least 15 months on average (22 months to cover the cost of volunteer time).

The follow-up data for TOML is such that it is not possible to determine whether or not those who successfully complete the programme manage to maintain their new lifestyle, the proportion who lapse and after what time period has yet to be determined. It is not, therefore, possible to state whether TOML has achieved the break-even point.

11.8 Recommendations

To determine whether or not those who complete TOML manage to maintain a healthier lifestyle, a follow up survey of stakeholders (volunteers, service users, former service users) is recommended. This could determine the value volunteers get from participation in the programme and progress of former services users after one, two and three years.

Costs which might have been included in the analysis had data been available include:

- Alcohol related A&E and GP visits in the year prior to treatment
- Housing difficulties
- Job losses and/or relationship breakdown where drinking was a primary cause
- Any alcohol-related contact with the criminal justice system
- Reasons for referral to TOML
- The proportion of TOML clients who go on to become volunteers and mentors
- For the purposes of service development, where clients decline to engage with TOML or drop-out, it would be useful to know the reasons why.

Benefits which might have been included in the analysis had data been available include:

- Stakeholder perceptions of the additionality of TOML, *i.e*. an identification of 'what has changed' as a result of the programme
- Stakeholder estimation of the qualitative value of participation in TOML.

Chapter 12: Sustainability

Key messages

- Staff were fully aware of the requirement for further funding to retain the TOML project and its model in the current form.
- Three features of the TOML service were highlighted as most sustainable including the volunteer and peer supporter work, group work, partnership and training. The latter was seen more as a legacy of the project rather than a service that could continue without TOML.
- Staff reflected that this group of older people had different needs and would not fit easily into a 'standard model' of service, necessitating the retention of a specialist older people alcohol service.
- Ideas for future service development primarily included the further development of existing services in the TOML model, in particular the TOML training, groups, volunteer and peer support programme and increased working with family members and carers.
- Increasing the number of staff was seen as key to developing the service.

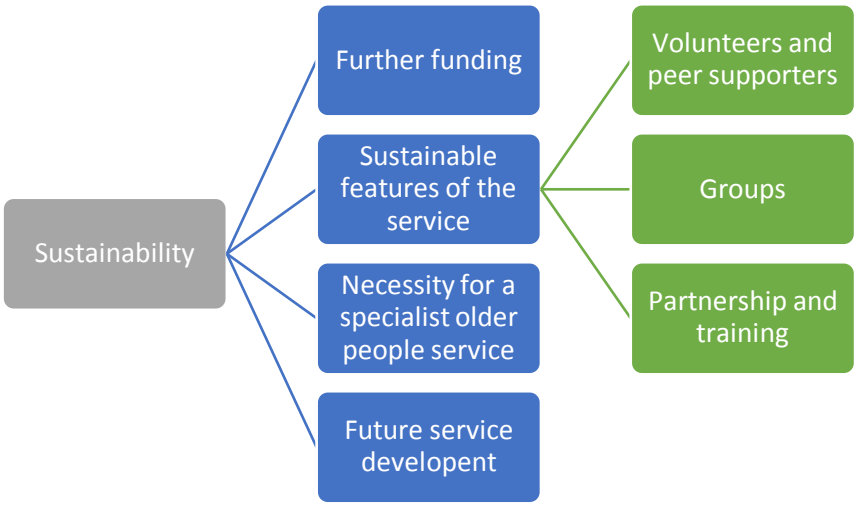
12.1 Introduction

One of the key aims of the evaluation was to identify participants' views on the extent to which the project's activities were sustainable beyond the end of the three-year funding for the project. Without question, all participants felt TOML was an important project and a well needed service. They also felt there would be a gap in service provision if it were to close.

12.2 Findings: professionals' perspectives

The professionals identified four main areas related to the sustainability of TOML (see Figure 12.1 below):

Figure 12.1: Professionals' perspectives on the sustainability of TOML



Further funding

Responses from a range of staff reflected the reality of the need to find further funding to sustain the service as it currently stands:

> Well, that's my fear, is what happens afterwards? Because somebody, for it to continue, it has to be funded by somebody (TOML staff member 10)

> But that is a real challenge, I'm hopeful that CCGs are the way forward, I'm a bit gloomy about what will happen in Birmingham but I have to be optimistic about how, if we can't embed it, get it sorted in Birmingham, we just pick it up and we take it elsewhere really. (TOML staff member 11)

> We would love, we'd love to just be able to continue it. You never know what happens with funding and situations, but you know, we will actively be looking at schemes and things that we can a bit nearer the time to try and keep things going. (TOML staff member 1)

One participant felt the structure of the service would not be supported or funded going forward and that looking at each element of it and their sustainability may be the way to "ensure that older adults' needs are kept on the radar" (TOML staff member 9).

Sustainable features of the service

Staff also spoke about particular features of the service which they felt were sustainable if no further funding was found, or would leave a legacy of some kind for TOML. These included the volunteer and peer supporters programme, the awareness raising and partnership work, the groups and the training provision:

Volunteer and peer supporters

> I think the volunteer programme could be sustainable, even if we aren't granted any further funding, I think the learning and the practice that's been put in place which is age specific, the volunteer programme, would be sustainable throughout Aquarius because I think that's something, that work with the volunteers, that can be taken forward, the learning can be used and developed upon (TOML staff member 3)

One respondent mentioned plans to develop the training and focussed supervision for volunteers with the possible use of role play to support people to deal with difficult situations. They also mentioned targeting volunteer recruitment to attract particular sets of skills.

Groups

The groups were felt to be sustainable providing volunteers were able to facilitate them if TOML was no longer funded as the volunteers would still be supported by Aquarius. Staff also reported making use of the REAP (Recover, Empower, Achieve, Participate) project – a mutual aid group developed in partnership with Aquarius and now a community interest company in its own right running its own groups which TOML people access. REAP had

moved its focus from general adults to older people and families. This was seen as an opportunity to sustain some of their work through strengthening and building on the partnership with REAP and sustain those groups already in place.

> With that, we have a project that we work with called the REAP project. So, with friends and families, we've been referring a lot of them to the REAP project as well as the Kinship Care one in Aquarius. That's helped greatly because, as well as we're helping the focal clients one to one, we know that their families are getting support at the same time. (TOML staff member 7)

One person felt that because people had become more used to attending groups with the TOML project, this may predispose them to using other groups if TOML came to an end.

Partnership and training

The partnership work and training components were seen to have benefits at very least for the dissemination of knowledge:

> A lot of other services that have worked with us, you'll see the benefit of what work we've done. I think if anything, a lot of the services will be more aware of the problems that we've faced whilst working together. (TOML staff member 4)

There was a general sense that, with the exception of CRI, their partnership work had gone well and new partnerships had and were emerging. These included work with safeguarding and vulnerable adults' panels, the fire service, GPs, hospitals and ambulance teams, mental health services, iCare, police, student nurse community placements, Head Start, and young people volunteers for a summer event. However, given funding challenges for many partner agencies, staff identified the need to seek out new partners as others close. Staff reported being aware of the need to network and learn about new projects.

In terms of training, some staff felt the sustainability would be in the preparation work done with future generations of health and social care staff:

> We've had a lot of students, we continue to have a lot of students, mental health students, nursing students, medical students, social work students. We're constantly teaching those future professionals how to deal differently with the older generation … so there's a lot of sustainable work going on in the teaching with them. (TOML staff member 1)

> … we've also looked at training other professionals such as the fire service, police service, other agencies that are particularly working with older adults or might come into contact with older adults who need to be aware, so … that gives some sustainability generally … (TOML staff member 9).

Some staff felt the teaching and coaching style of the interventions offered would allow people to sustain the changes they make:

> …there's a lot of teaching and coaching in our interventions…there's a lot of stuff that's learned, that people can then pass on to other people, that they're trying to support, the training of the volunteers and the peer mentors, they are then like a new generation armed with that knowledge. (Interviewee 1)

Necessity for a specialist older people service

There was an unequivocal message from some staff that their experience of working within an older people service was so different from other mainstream alcohol services that they did not feel the work could be absorbed into a standard adults' alcohol service:

> … I think it would be a tragedy if it wasn't, such a missed opportunity because when this service was first started, my view was what an opportunity that we've never had before, to develop a service for this age group. If it can't continue and develop after Time of My Life, I just think that would be criminal. (TOML staff member 10)

> I mean I don't know about stats actually but I never met more [people in their] 80s/90s than I do now… I think without having a specialist service I think it will probably get lost again … I think it's important to have something separate … because there are so many different needs when they're older. (TOML staff member 6)

> I think that older people don't necessarily fit into a standardised model that other services use, that's why they tend to drop out of that service, they find it very difficult to remain within that service… . (TOML staff member 3)

> I think it's a really valuable service and I think we have to reflect, it would be good for us to make sure we reflect with commissioners about the specific needs of older adults and doing peer support and volunteering right. It's hugely beneficial. (TOML staff member 9)

There was a genuine concern among staff about what would happen to the people if some kind of specialist service for older drinkers was not maintained. One person asked:

> Where will these people go and who will treat them as a specialist group of people? Who will treat them as you know, the way that we've learned to treat them..?" (TOML staff member 1)

One participant felt that it was important to 'skill up' other professionals, particularly those in older people's services, to work with alcohol issues "rather than creating a specialism around this".

Future service development

In spite of concerns about future funding, staff identified a number of ways the service

could be developed. Expanding the service both in terms of resources and scope was the main way forward with ideas about new commissioning arrangements, for example, the local CCG (Clinical Commissioning Group) or extension to Big Lottery funding.

A number of staff wanted to see an expansion of the TOML services including the TOML training service for other health and social care professionals, the group activities, growing the volunteer and peer mentoring programme, and greater working with family members and carers. Increasing the number of TOML staff and resources to the project was key to achieving this.

12.3 Discussion

The reality of sustaining a project such as TOML is a requirement for further funding. As the economic evaluation has highlighted, improving the monitoring data collected will allow a cost-benefit analysis to be conducted.

Aquarius has been subject to significant changes since the start of the TOML project as a result of the retendering process for Birmingham adults' substance use services, of which it previously delivered a significant part. TOML staff were well aware of the recommissioning agenda which saw the loss of colleagues and services from Aquarius and a new team and organisation, CRI, taking its place to deliver Birmingham services. The evidence in this report shows that TOML staff and service users were operationally affected by this transition to a new provider to varying degrees but that TOML has been protected from the subsequent cuts due to being independently commissioned from the Big Lottery Fund. In the current climate of serious cuts to statutory public health and social care budgets, this independence of funding is likely to be paramount to the continuation of the service.

Despite the ageing demographic in the UK and the evidence of increasing harm among older people from alcohol use (see chapter 1), the wider alcohol and drug policy context has done little to recognise older people's drinking as requiring separate policy or practice attention. However, attention may be assumed to mean investment and therefore highlighting a need at a national level then not investing is likely to attract criticism. The only policy concession, as identified in chapter 1, is that the new alcohol unit guidelines have listed older people as among those who should take more care in their drinking as they could be more susceptible to harm (DH, 2016). This invariably supports a discourse around individual responsibility and self-blame rather than direction, support and intervention from the State.

At a local level, Public Health Birmingham's *Drug and Alcohol Needs Assessment* (2013/14) made reference to the ageing population but pointed out that Birmingham's older population is growing at a far slower rate then the average national rate of growth in this group. Indeed, it highlighted its 'young age profile' in population projections:

> Population projections suggest that Birmingham's population is expected to grow by more than 150,000 between 2008 and 2028. Over this time Birmingham's young age profile will see the working age population grow at nearly twice the national rate, whereas the number of older people in Birmingham will grow by less than half the national average. This means

> that Birmingham will have an advantage in people of prime working age that will persist for some time. In 2029 the proportion of people in England who will be aged 50 or more will be 40%. However, in Birmingham this proportion will have only risen to 29%. (Kilgallon 103: 8)

Bringing together the current climate of austerity in public health services and commissioning structures with this local alcohol and drug needs data suggests that public health funding for older people's alcohol services is unlikely to be a priority. This, in spite of the practice-based evidence of demand and the wider costs to health and social care associated with older people's drinking. This reinforces the need for independent funding as the circumstances most conducive to sustaining the TOML project.

The TOML model, however, fits with another potential commissiong structure in that its work spans health and social care for older people. The TOML model, with the menu of services on offer, represents a fundamental shift from 'traditional' alcohol service provision of 1-1 practice and some supporting, alcohol-focussed activities. It offers a model where alcohol service provison may be just one part of the service and the alcohol service supports the older person with a range of health and social care needs, not just the alcohol-specific concerns. It is possible that in localist policies that mandate closer health and social care working and joint budgets, models such as TOML are no longer the responsibility of substance use budgets only and could be jointly commissioned from budgets for older people, public health and social care, particularly given the co-existing social isolation concerns.

The key question raised in relation to TOML's sustainability is 'Does TOML need to exist to do this work?'. It is possible that individual components of the work could be absorbed into wider agency practice if coordinated well. For example, it is possible to sustain the training offer as part of Aquarius' services. Partnership work can be sustained through organisational collaboration and joint work, and individual staff building positive working relationships. Group activities could be made available to Aquarius' clients more widely, indeed to partner agencies' clients too, thereby providing a greater pool of service users to populate the groups. Aquarius could continue to support its partnership with REAP. It is also arguably preferable to offer a more holistic model to all service users providing cost effectiveness can be demonstrated.

However, what appears to work well is that the TOML model prioritises this older age group and, as has been evidenced throughout this evaluation, prioritises the specific identification, and understanding, of the needs of this group of people compared with younger service users. The combined package of services that comprise TOML has been built with this group of people front and centre. Experienced staff have spoken emphatically about their surprise at the different challenges and opportunities this group presented for service provision. They have also spoken about their learning and their skills development specific to the needs of this group. To dilute the service would risk losing the focus of work on older people, which are widely acknowledged as a group of people facing increasing alcohol-related health and social harm that will require more attention not less. Moving to a more dispersed model risks:

a) losing expertise and knowledge clearly developed by staff as a result of the focussed work with this group of older people,
b) losing the time/flexibility in mainstream services to do the home visits and holistic work through which the strong therapeutic relationship is built,
c) losing the success in accessing a group of older people identified as 'hard to reach' and the value many people place on having an 'age -specific' service
d) losing the quality and consistency of staff-client relationships that both staff and service users have identified as being so integral to the TOML model and practice.
e) losing the opportunity to further develop and evaluate the TOML model.
f) potentially losing funding opportunities if the component parts are absorbed into mainstream service provision.

Furthermore, so much of the TOML model speaks to shifts in current substance use policy agendas which prioritise recovery-oriented approaches, approaches which acknowledge the wider health and social care needs for people changing problematic substance using behaviours (H.M.Government, 2015). These approaches move beyond the individual, substance focussed work to look at social and family support, employment needs (broadly interpreted), and physical and mental health and wellbeing.

12.4 Summary and recommendations

Without further funding the sustainability of the quality of relationships with service users and the depth and breadth of the work of TOML is in doubt. Evidence about the global ageing demographic is unequivocal. So too is the growing body of evidence that older people's problematic substance use is resulting in increasing harms to health and wellbeing. This suggests that models such as TOML have an important contribution to make to the future of alcohol services for this expanding group of people.

Recommendations

1. Seek funding to continue a specialist service focussing on older people's alcohol consumption.
2. Consider organisational structures to embed the volunteer and peer supporter services into wider service provision, along with the training work and group work should funding not be available immediately.

Chapter 13 – Project Overview and Discussion

> The 'findings' of realist evaluation thus always try to pinpoint the configuration of features needed to sustain a programme (Pawson and Tilley 2004: 9).

Chapter three introduced the key concepts comprising a realist evaluation approach: context, mechanisms, and outcomes. Realist evaluation also advises the development of 'programme theory' at the start of the evaluation process - effectively, these are hypotheses positing why a programme works, for whom, when and how – and for these theories to be tested through the evaluation. For this evalution, an adapted and exploratory approach to realist evaluation was used. It did not set out with early programme theories given TOML was a new project with newly developing services within it. Programme theories were developed over the course of the evaluation and will need further testing to determine their accuracy.

This chapter provides a summative discussion of the three key concepts of realist evaluation in relation to the Time of My Life project before bringing them together in a final theoretical model that encompasses the findings of this evaluation in terms of what works, for whom, and why.

13.1 Context

> Realism utilises contextual thinking to address the issues of 'for whom' and 'in what circumstances' a programme will work. … what is contextually significant may not only relate to place but also to systems of interpersonal and social relationships, and even to biology, technology, economic conditions and so on. (Pawson and Tilley, 2004: 7/8)

Context is therefore those circumstances that facilitate the mechanisms of a programme to work.

Chapters 1 and 12 began the consideration of contextual factors through discussions of the wider policy context of older people's alcohol consumption and the ageing demographic in the UK. However, at a practice level, the context for the development of the TOML service was one which recognised that older adults with alcohol problems, and other health and social care needs, were not accessing mainstream alcohol services.

The TOML model was developed to meet this specific need and was grounded in community and partner consultation and tested operationally with a pilot service. Combined with evidence demonstrating increasing alcohol related morbidity and mortality for older people, the local knowledge and wider evidence base supported the development of a specific alcohol service for older people.

TOML was also developed within a parent service that was established within the City. The service was already knowledgeable about the profile of the residents in each of the City's

four quadrants. With services covering the whole City, this knowledge of different cultural needs informed the decisions about some aspects of service provision, for example, knowing that an overtly alcohol-focussed group would not be as easily accepted within some BME communities compared with a group focussed more on social support.

Furthermore, the social ecological model underpinning the organisation was already established. Aquarius' approach is one that views problematic alcohol use as a way to cope with difficulties and one that the individual, and family, are able to overcome given the right support and alternatives to drinking (Aquarius, 2016). Subsequently, interventions are focussed on working with people to explore alcohol's role in their lives and how they might choose to change that function and their drinking behaviour. Because this was in place, TOML staff did not need to debate the theoretical approach underpinning the new project nor familiarise most staff with its principles.

TOML is staffed by a number of Aquarius employees with longevity in the organisation and with experience of working with people with alcohol problems. This is reflected in some of the professionals' interviews, notably in their openness to reflect on learning and assumptions they brought with them from working in the mainstream adults' service. Some of these staff, in addition to Aquarius' Chief Executive, will have enjoyed professional contacts and partnerships with other services from the outset of the project or, at very least, they will have had an awareness of the City's health and social care agencies with whom they wanted to develop TOML partnerships.

In sum, the context in which TOML emerged was not one which required the development of agency principles, values and expertise in alcohol service provision from the start. This was already established in its 'parent' agency, Aquarius. TOML was therefore located in a local context which built on an existing body of knowledge and practice. With additional consultation and learning around age specific issues, this gave it an important head start in its launch and development, particularly in a wider funding context of instability and insecurity.

13.2 Mechanism

In realist evaluation, it is the mechanisms of a programme or service that are pivotal to understanding the processes by which it works. Pawson and Tilley (2004: 6) state that "[m]echanisms describe what it is about programmes and interventions that bring about any effects". They add "…it is not programmes that work but the resources they offer to enable their subjects to make them work…".

Resources and mechanisms are seen to be hidden features of a programme that are not visible to the people receiving it. As stated in chapter 3, Pawson and Tilley refer to them as the hidden workings that drive the hands of a clock. This evaluation found four key programme features that could be considered 'mechanisms' in this sense and which underpin the TOML programme:

1. An *understanding* of the particular, and more complex, needs of older people with alcohol problems.
2. A *programme model* which builds on this understanding, establishing strong

therapeutic relationships.

3. A *menu of support options* that offers choice about who to engage with, when and how.
4. A *flexible period of engagement*.

However, these are broad programme features and potentially belie the mechanics or 'resources' of each feature that effect the change. For the TOML project the *core resource is the staff*, who understand the importance of relationship building and who have shifted their practice to facilitate the depth and closeness of relationships this group of people requires for effective programme engagement. This is amply illustrated by one TOML staff member who said:

> They know they can come to me with anything and I will, with all my passion, try to sort it or guide them or direct them in the right direction of how things can get better or where they can get advice from, or what I can do for them. (TOML staff member 2)

The reflective abilities of the staff to learn and develop the service, and their own knowledge base, and understand the need to work differently are what operationalises the four core mechanisms listed above. Other key staff resource range include the *leadership* of Aquarius in recognising a need for a better service for older people and committing organisational resource to its ground work, pilot project and subsequent development; the volunteers and peer supporters who provide the listening and visiting services; and support through group activities which enables TOML to offer additional and after care support to service users.

Little was said about particular methods of working or intervention tools. These appeared to be less important than the relationships developed, the advice given and encouragement given by staff and volunteers, and the trust and confidence service users built through receiving the service.

Further resources are those which comprise the broad programme features. For example, it was clear from this evaluation that in operationalising an understanding of older people's needs, that knowledge of health issues and social isolation would be required. A different type of assessment procedure was developed that adopted a 'more conversational tone' as one TOML staff member described it. Important too, was the willingness to develop a depth of engagement with the individual and family members.

The mechanisms that comprise the programme model include a willingness and commitment by staff to engage with a holistic service model which includes home visits, hospital outreach and peer support, for example. Further, it includes their willingness to promote the menu of support options to service users where appropriate including the group activities, listening and visiting services, and peer support opportunties.

13.3 Outcomes

In realist evaluation, outcomes can be both "intended and unintended consequences" stemming from the various mechanisms identified above and the contexts in which they

occur. The outcomes of the TOML project include:

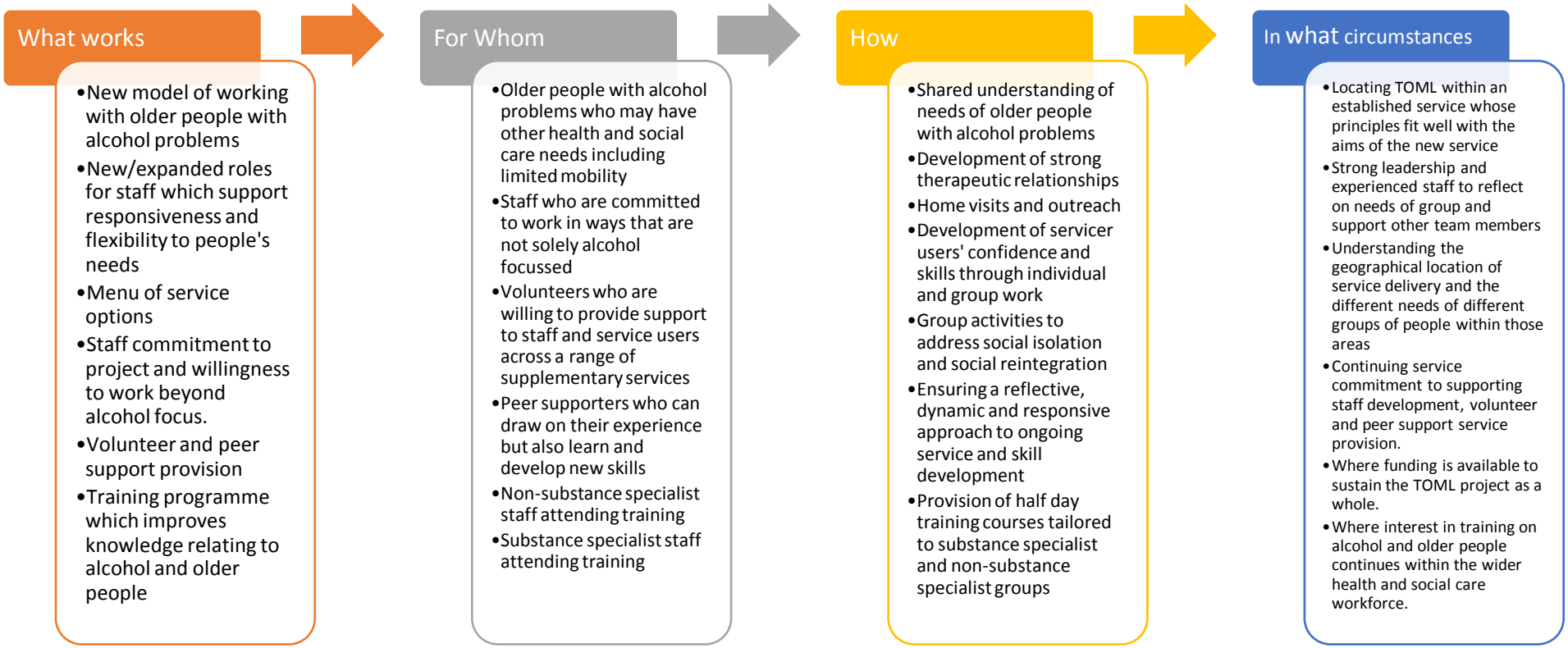
1. *Access to an older age group* ('older old' people) who, staff report, were not normally seen in services due to health problems or issues with mobility.
2. *Delivering a new model of service* that allowed often complex health and social care needs to be addressed alongside a focus on changing alcohol behaviours.
3. S*tronger and closer therapeutic relationships* between staff and service users as a result of the greater immersion in people's lives. This was experienced largely through the 1-1 work as group activities do not usually allow for that depth of therapeutic relationship to develop.
4. Reported *changes in drinking behaviour and lifestyle change* through the mechanisms of staff-service user relationships identified above and the range of service options on offer. In addition, TOML monitoring data demonstrate that 75% of people receiving the individual service had shown a reduction in units (Aquarius, personal communication, 2016). Some of these were still drinking at levels above recommended units although others were abstinent.)
5. Reported *increases in health and wellbeing* from service users, particularly in relation to increased confidence and skills, less social isolation, and feeling generally happier and healthier.
6. A *body of TOML volunteers and peer supporters* providing significant resource across the TOML service offer.
7. A *training programme* that evidenced improved understanding of older people's alcohol use among substance specialist and non-substance specialist staff.
8. The rapidly increasing *opportunities it offered peer supporters and volunteers* – some of whom had come through the Aquarius service as service users. This transition from service user to peer supporter and/or volunteer staff member is a great achievement for people who had long term substance problems and contributes to the wider recovery agenda currently focussing on reintegration of people with substance problems back into community and family life.
9. A *preventative resource* via the group activities. This is easily accessible in local communities and helps to combat social isolation and related difficulties that are known to contribute to the onset and maintenance of problematic drinking.
10. An unintended outcome might be the *limited success of some group activities* and the amount of effort staff needed to pay attention to the groups. There appeared to be a number of contexts in terms of location, and focus of the group activity, which determined the success of the group or lack thereof (if group attendance indicates success).
11. A further unintended outcome might be the *inability to conduct a cost/benefit economic evaluation* of TOML due to a lack of necessary baseline data. However, a break-even economic analysis was conducted and could be strengthened with information on longer-term outcomes of TOML service users.

Fewer outcomes are evident for family members given the small size of the group involved in the evaluation but there was evidence, and appreciation, of the support received both in their own right and through the support of their relative.

13.4 CMOC: context-mechanism-outcome pattern configurations

The final element of realist evaluation draws together the three core components in "models indicating how programmes activate mechanisms amongst whom and in what conditions" (Pawson and Tilley, 2004: 9). Figure 13.1 below offers a model for the TOML project in terms of highlighting the key findings from this evaluation expressed in relation to what works, for whom, how and in what circumstances.

Figure 13.1 – What works, for whom, how and in what circumstances



From highlighting these components, it is possible to develop 'programme theory'; theories that explain how different aspects of the TOML programme fit together:

Programme theory 1: the TOML model of working supports older people with alcohol problems with additional health and social care needs through a shared understanding of the needs of older people, strong leadership, and set within an established, and experienced, alcohol service provider.

Programme theory 2: the new and expanded roles for TOML staff are effective in helping older people with alcohol problems i) develop strong therapeutic relationships and ii) achieve change within the context of a focussed service for older people with problematic alcohol use. *(These relationships allow staff to provide flexible, accessible, reliable, trusted support that gives service users the encouragement and confidence to address the issues that underpin their drinking as well as the alcohol use itself. The therapeutic relationship is valued as an end in itself, but it is also a mechanism by which key problems are addressed)*.

Programme theory 3: volunteer and peer support services enable older people with alcohol problems to develop confidence and skills through group work and additional support beyond individual service provision. This is sustainable providing the volunteer and peer support resource continues to be supported adequately through training and supervision.

Programme theory 4: the TOML training programme results in greater knowledge of alcohol and older people for both substance specialists and non-substance specialists through the provision of half day training courses. This is sustainable while demand continues within the wider health and social care communities.

Programme theory 5: staff commitment is evident through the willingness of staff to work in ways that are not solely alcohol focussed and the ability to reflect and respond to the dynamic nature of skill and service development. A dedicated TOML project will provide the environment for this to continue.

Programme theory 6: the menu of service options on offer to TOML service users is made possible by the contribution of volunteers and peer supporters whose provision of group activities and outreach services, e.g. listening and visiting services, is sustainable while funding continues for both TOML and the administration of volunteer and peer support provision.

For a traditional approach to realist evaluation, programme theory would be hypothesised at the start of the evaluation then refined and tested at the end (Pawson and Tilley 2004). Due to the nature of this new and developing service about which little was known, exploratory work was needed as part of the evaluation approach, therefore theoretical development has begun at the end of the evaluation period. Instead of refining it, theory is proposed here for future testing, particularly if the model is expanded or rolled out on a larger scale.

13.5 Summary

Realist evaluation accepts that a programme will 'work', or not, as a result of a whole set of influences. It rejects the notion that one outcome is evidence of success and that it can therefore be replicated regardless of context or mechanisms. What this evaluation has shown is that the Time of My Life project has operated well within a challenging policy and practice context at national and local levels. The model it has developed is one that speaks to wider policy agendas of recovery and holistic approaches while at the same time maximising its service provision through the effective use of a body of volunteers and peer supporters.

What is clear from this evaluation is that the vital ingredient of the TOML model is its understanding of the particular needs of this group of older people. It has translated this understanding into operational terms and communicated this to service users through a staff group capable of building strong therapeutic relationships and a reflexive and dynamic approach to the project's development.

Chapter 14 – Summary of recommendations

The following list of recommendations brings together all those listed at the end of each chapter in this report. They have been split into more project or practice focussed recommendations and suggestions for further data collection or analysis.

14.1 Practice recommendations

1. Disseminate the model, the learning from it, and its development as an alternative model to engaging and working with older people with alcohol problems and co-existing needs.
2. Consideration could be given to developing a toolkit on setting up a service for older people with drink problems.
3. Continue to commit resources to recruiting, training and retaining TOML volunteers and peer supporters in order to sustain their contribution to the TOML model.
4. The OCN course and its success should be highlighted and disseminated as good practice.
5. Given people's willingness to discuss their own experiences and journeys through services to volunteer and peer supporter involvement, consider developing short audio-visual clips drawing on these experiences as a recruitment and promotion tool. This should include people without personal substance use histories too.
6. Consider carefully the range of tasks volunteers and peer supporters are involved in and the ongoing supervision, monitoring and development needs to support and retain them.
7. Ensure there are clear channels of communication between TOML staff and volunteers and peer supporters to maximise feedback and to help new volunteers and peer supporters to embed into the team as quickly as possible.
8. Review monitoring and recording of client data to ensure reliable analysis of unit consumption pre and post TOML service for example. Build in a follow up period of up to 6-12 months post discharge to support effectiveness analysis.
9. Continue to monitor the attendance and focus of groups in line with the TOML project's objectives.
10. Review the continuation of groups at which there are no or few TOML clients and whose needs are not social isolation *in addition* to alcohol-related support. (There may be good justification to continue a 'community group' if it serves as a preventative measure and provides a way to access particular communities with alcohol information providing a) it is providing alcohol information and b) that this type of community social group meets TOML project objectives).
11. Consider options for shared transport arrangements or other travel support to maximise group attendance.
12. Consider service provision out of 'office hours' to maximise support offered to family members who work.
13. Clarify to staff whether there is an age limit relating to family work.
14. Review whether training on alcohol and domestic violence/elder abuse is in place as part of a rolling programme for all TOML staff, volunteers and peer supporters.
15. Lessons learned from practice should be fed into the model dissemination and/or toolkit development.

16. Further partnership development work with the new provider CRI (CGL) to facilitate pathways between services would likely benefit service users.
17. Where opportunities arise, funding for additional staff would ease pressure on the small staff team and allow longer hours to cater for working clients and family members.
18. Be mindful of service users' concerns about a lack of continuity of staff when roles change or people are promoted within the small team. This is important given the centrality of the therapeutic relationship to the TOML model. Where possible, continuity needs to be preserved. In this context, staff need to remain open and realistic about boundaries given some service users feel they'll 'always be there' for them.
19. Review promotion of, and referrals to, the visiting service to ensure that service use is maximised.
20. Formalise feedback routes to, and from, the volunteers and peer supporters about their contribution and development needs.
21. Seek funding to continue a specialist service focussing on older people's alcohol consumption.
22. Consider organisational structures to embed the volunteer and peer supporter services into wider service provision, along with the training work and group work should funding not be available immediately.
23. The training was received well and should be continued, however consideration could be given to booster sessions or organisational support to ensure change in practice.

14.2 Further research

24. Future research should include an outcome measure that explores health and well being.
25. Further collection and analysis of data which identifies a) how many people attend groups as part of a wider TOML package, b) how many people attend groups only, c) how many people attending groups are TOML clients, and d) what percentage of volunteers and peer supporters supporting groups have progressed from addressing their own substance problems into a volunteer and peer supporter role, would help to shore up future decisions about viability and function of the group activities.
26. Further research is needed with a larger group of family members to determine their views on, and experiences of the TOML service.
27. Conduct a follow up survey to determine the progress of former services users after one, two and three years.
28. Review data collection to include:
    - Alcohol related A&E and GP visits in the year prior to treatment
    - Housing difficulties
    - Job losses and/or relationship breakdown where drinking was a primary cause
    - Any alcohol-related contact with the criminal justice system
    - Reasons for referral to TOML
    - The proportion of TOML clients who go on to become volunteers and mentors
    - For the purposes of service development, where clients decline to engage with TOML or drop-out, it would be useful to know the reasons why.

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